NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Dalton Senior Living	RC- 1286	840 East Dalton Avenue	208-665-2100
Administrator	City	Zip Code	Survey Date
Bennett Kirk Goodin	Coeur d' Alene	83815	08/23/2024
Survey Team Leader	Survey Type		Response Due
Walker, Jenny	Health Care Initial Licensure + complaint investigation		09/22/2024

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. The former administrator stated the corporation was having her continue to admit residents even without having enough staff to meet the needs of the residents. The former administrator stated the corporation was all about "opening the two new buildings." The facility did not have enough staff for the three buildings, leaving the residents without supervision. There was one medication technician scheduled to pass medications to all three buildings and also had the responsibilities of cooking breakfast, providing assistance with ADLs for eleven residents, and pass morning medications in the Cedar building. This led the facility to receiving several non-core deficiencies for not having sufficient personnel and also receiving non-core deficiencies 009.01, 215.08.e, 215.08.f, 300.01, 305.02.b, 305.03, 310.01.c, 310.04.e, 320.01, 330.06.a, 330.06.b, 330.13.e, 330.14, and 600.04.a. The facility did not have a certified food protection manager and the kitchen inspection failed on 8/20/24, which included non-core deficiencies 450, 451.01.c, and 451.01.d.
2	.009.01. Criminal History and Background Check.	Two of seven employees, whose personnel records were

		reviewed, did not have a Department Criminal History and Background Check. The former administrator did not ensure the Department Criminal History and Background Checks were completed.
3	.215.08.e. Corrective Action.	The facility did not ensure effective corrective action was put into place to prevent recurrence for Resident #3 and Resident #5. For example, Resident #3 fell on 2/4/24, 2/10/24, 2/27/24, 3/8/24, and 4/29/24 and there was no corrective action put into place after these falls. Resident #5 fell on 4/17/24, 5/5/24, 6/2/24, and 7/3/24 and there was no corrective action implemented after these falls. The previous facility nurse was unavailable for interview.
4	.216.02. Written Agreement.	Residents #1, #7, and #8 did not have new admission agreements in place between them and current ownership following a change in ownership. The Business Office Manager stated this was the responsibility of the former administrator, who did not ensure new admission agreements were in place.
5	.250.09. Resident Sleeping Rooms.	The facility's water temperatures were not consistently maintained between 105 and 120 degrees F. On 8/19/24, the water temperature in several resident rooms, located in rooms in the Cedar building, were observed to range from 69 degrees F to 101 degrees F. The maintenance director stated he was unaware of the water temperature ranges.
6	.260.06. Toxic Chemicals.	The facility was not maintained in a clean, safe and orderly manner. For example: Cedar, Fir, and Oak buildings had weeds in the back courtyard and front walkways. The Cedar building had melted and missing siding on the front of the building. The Fir building had laminate flooring that was missing in several places near the baseboards. The Oak building had dirty ceiling vents and light fixtures. The exterior courtyard in the Oak building was observed to have bent fencing, garbage on the tables, and overgrown weeds throughout. The newly appointed administrator stated he was aware of the environment and had recently hired a company to address the

		yard.
7	.260.07. Toxic Chemicals.	Toxic chemicals were observed to be stored in an unlocked area which was accessible to cognitively impaired residents on three different occasions from 8/19/24 to 8/22/24. Dishwasher detergent pods, ZEP stainless steel cleaner and polish, unlabeled disinfectant surface cleaner, were all observed under the main kitchen sink in all three buildings. In the memory care building a cleaning cart was left in the back hallway during these occasions, which included bleach.
8	.300.01. Licensed Registered Nurse (RN).	The facility nurse did not complete initial nursing assessments for Residents #2, #3, #5, #6, and #9. Additionally, the facility nurse did not complete quarterly nursing assessments for Residents #1, #2, #3, #5, #6, #7, and #8. The current facility nurse stated the initial and quarterly nursing assessments were not completed by the previous facility nurse.
9	.305.02.b. Quarterly Nursing Assessments.	The facility did not ensure residents consistently received their medications and treatments as ordered. For example, Resident #7 did not receive 34 doses of their metoprolol for blood pressure from 7/17/24 to current. Resident #7 had an order for quetiapine fumarate twice a day and was receiving it three times a day for 5 days as of 8/15/24. Resident #7 had an order for a mechanical soft diet starting 8/7/24 and received a hamburger patty on 8/20/24 for lunch. Resident #9 was admitted on 12/14/23 and did not receive their medications as follows: amlodipine, ativan, doxepin, lasix, olanzapine, oxcarbazepine, and pantoprazole. The facility nurse was not aware Resident #7 was not receiving their medications as ordered. The facility nurse stated the former certified food protection manager was aware of the diet change for Resident #7 and did not follow through. The facility nurse was not employed at the time when Resident #9 was admitted to the facility in December 2023.
10	.305.03. Change in Resident Health Status.	The previous facility nurse did not conduct nursing assessments when residents experienced changes in physical

		or mental health status. For example, when Resident #3 had a choking incident on 1/15/24 nor when they fell on 2/4/24, 2/20/24, 2/27/24, 3/8/24, and 4/29/24. When Resident #5 fell on 1/3/24, 4/17/24, 5/5/24, and 6/2/24, and experienced skin tears on three of those occasions and the facility nurse did not complete a change of condition assessment. When Resident #8 was found unresponsive on 2/12/24 and was sent to the emergency department, the facility nurse did not complete a change of condition assessment when the resident returned from the emergency department. The previous facility nurse was unavailable for interview.
11	.310.01.c. Medication Distribution.	The facility's medication refrigerator temperatures were not monitored and documented daily where insulin was stored. The facility had not documented daily temperatures for June, July, and August 2024. The residential care coordinator stated they were aware that staff were not consistently documenting daily medication refrigerator temperatures.
12	.310.01.g. Medication Distribution System.	Resident #5 did not have their PRN loperamide or lorazepam available to them and Resident #1 did not have their milk of magnesium available. The residential care coordinator stated they were aware that some residents had missing PRN medications as the previous residential care coordinator was not conducting medication cart audits.
13	.310.04.e. Psychotropic or Behavior Modifying Medication.	Resident #1 was taking lorazepam and escitalopram for longer than six months and Resident #2 was taking duloxetine for longer than six months. Resident #3 was taking Buspirone and duloxetine for longer than six months, and Resident #7 was taking Seroquel and lorazepam for longer than six months. None of these residents' had six month psychotropic medication reviews that included behavioral updates. The facility nurse stated the previous nurse had not completed the psychotropic medication reviews and that she was working on updating these for all residents'.
14	.319. COMPREHENSIVE ASSESSMENT REQUIREMENTS.	Residents #2, #3, #5, #6, and #9 did not have comprehensive

		assessments completed prior to being admitted to the facility. The facility nurse stated the previous facility nurse and former administrator did not complete the comprehensive assessments.
15	.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 #4 had wounds to their toes, sacrum, lower left leg and there were no instruction for staff on how to care for these wounds or who to notify if there was a concern. Resident #5's NSA did not clearly reflect their toileting and dressing needs from independent to two-person assistance. Resident #3's NSA described the resident as able to use their walker and walk behind their wheelchair for mobility; however the resident required total assistance for transfers and utilized a wheelchair which staff had to push for them. Resident #3's NSA also stated they were independant with eating; however the resident required cut-up food, cueing, and on occasion assistance with eating. Resident #8's NSA described the resident as independent; however they required one-person assistance for toileting, dressing, grooming, and bathing. The facility nurse stated she provided recommendations to the previous administrator but they had not updated the residents NSA's to clearly reflect their current status.
16	.330.06.a. Additional Resident Records.	The facility did not evaluate Resident #8's behaviors of yelling/cussing at staff, swinging at staff, and Resident #5's behaviors of swearing/yelling at staff and other residents, and refusals of medications and ADL's. The previous administrator was unavailable for interview.
17	.330.06.b. Additional Resident Records.	The facility did not develop behavior plans which included specific interventions for Residents #5 and #8 who engaged in maladaptive behaviors. See examples in non-core punch 319.04. The facility nurse confirmed the facility had not developed behavior plans for Residents #5 or #8.

18	.330.13.e. Personnel Records.	Four of seven employees, whose files were reviewed, did not have documentation they had completed 16 hours of orientation. Staff members and the Business Office Manager stated they received this training, but no documentation of the training was retained in the employee files.
19	.330.14. As Worked Schedules.	The facility's as-worked schedule did not document dates and times the maintenance director, weekend cook, activities director, marketing director, or concierge worked at the facility. Additionally, exact times worked were not documented for caregivers and medication technicians.
20	.450. REQUIREMENTS FOR FOOD AND NUTRITIONAL CARE SERVICES.	The facility did not meet the standards for the Idaho Food Code. Kitchen inspection failed. Mandatory re-inspection required within 10 days. Additionally, the facility did not have a Certified Food Protection Manager at the time of the survey. The facility nurse stated, to her knowledge, no current staff were certified.
21	.451.01.c. MENU AND DIET PLANNING.	The facility's current weekly menu was not posted in the common areas of all three buildings (Cedar, Fir and Oak), for residents to view. The kitchen manager stated he was unaware the menus needed to be posted in the common areas.
22	.451.01.d. Menu.	The facility did not maintain documentation of menu substitutions. The kitchen manager stated he was unaware menu substitutions needed to be maintained. Additionally, the facility did not serve the planned menu. For example, on 8/20/24, the menu documented springtime spinach and chicken salad was to be served and hamburger patties were served. On 8/21/24, the menu documented beef steak smothered with onions was to be served instead spaghetti with meatballs was served. The kitchen manager stated often times he did not have the specific foods on hand to meet the planned menu.
23	.600.04.a. Sufficient Personnel.	The facility did not have sufficient personnel on 8/19/24 for the night shift. The facility was left without sufficient staff, which left one building to be alone without supervision for a

		short period of time. On 8/21/24 at 9:15 AM, the Cedar building had breakfast items spread throughout the kitchen, the one medication technician was providing care to another resident, and two residents were sitting at the table waiting to be served breakfast. Resident #7 was upset that they did not received care's and was requesting their breakfast. The medication technician stated they were overwhelmed, because they were the only medication technician scheduled for all three buildings because another medication technician was a no-call no-show. The medication technician stated the residents were not receiving their ADL's this morning because they had to pass medications, cook breakfast, provide cares, and supervise Resident #6 that would wander into other residents' rooms. The medication technician stated the facility had been working short-handed for the last couple of months and it was "not fair to the residents that they were not receiving their care's that they deserved." The facility nurse stated when the administrator abruptly quit some of the care staff quit without notice as well.