NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Post Falls Ops, LLC, dba Guardian Angel Homes	RC-643	1070 East Mullan Avenue	208-777-7797
Administrator	City	Zip Code	Survey Date
Dakota Klinkefus	Post Falls	83854	08/23/2024
Survey Team Leader	Survey Type		Response Due
Lu, Melvin	Health Care Licensure and Follow-Up		09/22/2024

Item #	Rule (16.03.22)	Description
1	.009.01. Criminal History and Background Check.	One of ten employees, whose personnel records were reviewed, worked alone for at least seven shifts before the facility obtained their completed Department Criminal History and Background Check. Upon interview with the administrator, it was confirmed the employee had worked alone before the facility obtained the employees Department Criminal History and Background Check.
2	.300.01. Licensed Professional Nurse (RN).	The facility RN did not complete initial nursing assessments for Residents #1, #2, #3 and #6. Additionally, the facility RN did not complete timely quarterly nursing assessments for Residents #1, #2, #4, #7, and #11. The facility RN stated the facility was behind on completing nursing assessments. ***Previously cited 2/28/2020***
3	.305.02.a. Quarterly Nursing Assessments.	The facility did not ensure residents' medication labels were up-to-date with providers' orders. For example, Resident #2 had two bottles of fluorometholone on the cart, with an order to receive this medication three times daily. One of the bottles, however, documented to give one drop into the right eye twice daily. Resident #2 was ordered to receive two sprays of their saline nasal spray daily on a scheduled basis, as well as

		two sprays every four hours as needed. However, the label on the bottle documented the resident was to receive one spray daily on a scheduled basis and one spray twice daily as needed. Resident #3 was ordered to receive gabapentin 100 mg three times daily. There were two bubble packs of gabapentin on the cart; one label documented the resident was to receive gabapentin once daily at bedtime; the other label documented twice daily, up to three times if tolerated. The facility nurse stated the facility needed a new system in place to ensure the medication labels were concurrent with the providers' orders.
4	.305.02.b. Quarterly Nursing Assessments.	The facility did not ensure residents received their medications as ordered. For example, Resident #1 did not receive 61 doses of their medications, including Eliquis and levothyroxine, between June and August 2024 as the medications were not available at the facility. Resident #2 did not receive at least 61 doses of medications since June 2024, including multiple antibiotics for chronic conjunctivitis of the right eye. Also, on 8/13/24, Resident #2 was ordered to receive polymyxin B/trimethoprim drops four times daily, but at the time of survey, the resident was only receiving this medication three times a day. There was also a delay in residents receiving newly ordered medications or changes in orders. For example, Resident #2 was ordered to receive tobramycin drops and ointment for their eye infection as of 6/8/24, but they did not begin to receive these medications until 6/26/24 and 7/12/24, respectively. During observations on 8/21/24 and 8/22/24, the facility had run out of the tobramycin drops for Resident #2, and an unsampled resident was out of their scheduled hydrocodone. The facility nurse stated the facility needed to implement a more effective system to ensure medications were available for residents at all times and given as ordered.
5	.310.01.c. Medication Distribution.	The facility did not maintain the medication refrigerator temperatures between 38 and 45 degrees F for all medication refrigerators. For example, the medication refrigerator

		temperature log for the Timber house documented the temperature was below 38 degrees F 44 times between July 1, 2024 and August 20, 2024. The log documented the temperature to be as low as 32 degrees. The medication technician stated there were medications such as liquid Morphine and other medications that required refrigeration stored in the refrigerator.
6	.310.01.g. Medication Distribution System.	The facility did not ensure all residents' as-needed(PRN) medications were available. For example, Resident #2 did not have Senna, loperamide, or Biofreeze available; Resident #6 did not have hyoscyamine, loperamide, and as-needed vancomycin available, which had been prescribed due to their history of clostridium difficile(C-diff) infection. Resident #7 did not have loperamide, lorazepam, lomotil, or scopolamine available. The facility nurse stated the facility needed to implement a more effective system to ensure PRN medications were available for residents.
7	.310.02. Discontinued and Expired Prescriptions.	The facility had an accumulation of unused, discontinued or expired medications for more than 30 days. For example, there were several baggies with syringes of liquid morphine, which had been expired for at least 30 days, observed in the medication cart in the Tudor house. Additionally, there were multiple medications observed in both the Craftsman and Cottages homes including Fentanyl patches that had expired as far back as November 2023.
8	.310.04.e. Psychotropic or Behavior Modifying Medication.	Residents were taking psychotropic medications for longer than six months and did not have six-month psychotropic medication reviews completed at the time of survey. For example, Resident #1 was taking risperdal, and Resident #2 was taking quetiapine and as-needed lorazepam and haloperidol. Resident #4 was taking clonazepam and Zyprexa. The facility nurse confirmed the reviews were not completed for these residents. ***Previously cited on 2/28/20***
9	.320.08. Periodic Review.	Negotiated Service Agreements (NSAs) were not consistently

		updated to reflect significant changes in residents' health status, which was particularly vital in this facility as there were multiple agency staff caring for residents in the various buildings and regular staff members who picked up shifts in other buildings. For example, according to some staff, Resident #1 had a history of a left heel pressure injury and was to wear protective booties while in bed or have the heels floated, and other staff who did not realize the resident was to wear the booties. Resident #1 had also injured their right second toe in July 2024 and left second toe in August 2024, and some staff were not aware of these injuries or how to care for them. Resident #1's NSA did not address the resident's skin condition or wounds, nor how to care for these areas. Resident #1's NSA also documented they were receiving hospice services, including bathing on an as-needed basis and would provide supplies for the resident, but they had been discharged from hospice in the spring of 2024. During interviews, at least two staff members stated they believed Resident #1 was still on hospice. Resident #4's NSA did not document their need for repositioning to prevent skin breakdown, for which the resident had a recent history. Staff stated they were aware Resident #4 needed to be repositioned but did not know how often it was to be completed. Resident #12 had an outside agency providing full time "companion care," which was not documented in their NSA. Multiple facility staff members were aware of the companion but were unsure how often the companion was supposed to be present with the resident. The facility nurse stated the facility nurses and administrator were responsible to keep the residents' NSAs updated to reflect the residents' current needs.
10	.330.04. Behavior Documentation.	The facility did not ensure all documentation requirements were met per rule. For example, Resident #1's preadmission assessment, dated 4/28/22, was signed with a first name only, with no last name and job title of the person performing the

		assessment. In addition, facility staff did not consistently document unusual events concerning residents. For example, Resident #1 had injured their right second toe sometime in mid July 2024, for which they were seen by their primary care provider, but the staff member who had observed the injury did not document the event. The facility nurse documented staff had reported to her Resident #2 was struggling to chew and swallow their food, but the staff members who witnessed this did not document this in the resident's chart. On 8/18/24, an agency caregiver reported to the "float" caregiver Resident #3 had fallen in their room, and the "float" caregiver documented this information in the resident's chart for the other caregiver. The facility administrator stated staff needed additional training to ensure all documentation met rule.