NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Lodge at Bristol Heights #1, The	RC-1259	2220 E Prairie Ave	208 457 3403
Administrator	City	Zip Code	Survey Date
Kari Hakala	Coeur d'Alene	83815	09/12/2025
Survey Team Leader	Survey Type		Response Due
Perry, Bradley	Health Care Licensure and Follow-Up		10/12/2025

Item #	Rule (16.03.22)	Description
1	.009.06.c. Use of Previous Criminal History and Background Check.	Three of four employees, whose personnel records were reviewed and required an Idaho State Police background check, did not have an Idaho State Police background check completed. Upon interview with the Administrator, it was confirmed the Idaho State Police background checks were not completed.***Previously cited on 7/25/23.***
2	.250.13. Secure Environment.	The facility had residents with cognitive impairments and a history of or who were at risk for elopement and did not provide a secure environment. On 9/8/25, Resident #5, who had cognitive impairments, residing in unsecured assisted living unit, was observed to exit the facility through an unsecured door before staff assisted the resident back inside. On this same date and throughout the survey from 9/8/25 to 9/11/25, Resident #5 attempted to enter other residents' rooms. Resident #5 was also observed taking or moving walkers belonging to other residents. Several staff stated Resident #5 required constant supervision and redirection to prevent Resident #5 from exiting the facility and entering other residents' rooms. The facility nurse stated she was unaware of Resident #5's attempts to exit the facility. The facility nurse confirmed Resident #5 would be unable to find

		their way back if they were to wander unsupervised outside of the facility. The facility administrator stated Resident #5 had cognitive impairment to the extent they would be unable to find their way back if they were to elope.
3	.305.02.b. Quarterly Nursing Assessments.	The facility failed to ensure residents' medications were given as ordered. For example, Resident #3 did not receive Arnicare Gel 15 times, atorvastatin and hydrochlorothiazide 6 times, metformin 17 times, and paroxetine 6 times in August 2025. There were similar examples for Residents #1 through #9. The facility nurse confirmed the medications were not given as ordered.
4	.305.03. Change in Resident Health Status.	The facility nurse did not conduct nursing assessments when residents experienced changes in physical or mental health status. For example, Resident #2 returned to the facility with a significant decrease in health status and became bed bound following a hospital visit on 8/31/25, and was not assessed by facility nurse. The facility Licensed Practical Nurse (LPN) confirmed these assessments were not completed. Resident #3 had three falls between 7/12/25 and 7/13/25 and was not physically assessed by a facility nurse. The facility Registered Nurse (RN) stated the assessments were not completed by him in person, and he took information from non-licensed care staff to complete over video and/or phone assessments, including descriptions of wounds such as skin tears.
5	.310.04.e. Psychotropic or Behavior Modifying Medication.	Psychotropic medication reviews were not completed for six of the sampled residents who required psychotropic medication reviews. For example, Resident #6 had been taking duloxetine and aripiprazole longer than six months. Resident #9 was taking risperidone, buspirone, and sertraline. Resident #7 was taking buspirone. The facility administrator confirmed the psychotropic medication reviews were not completed.
6	.319. COMPREHENSIVE ASSESSMENT REQUIREMENTS.	Pre-admission comprehensive and nursing assessments were not completed for residents #3, #4, and #7, including personal assistance needed, maladaptive behaviors, or the nursing

		assessment. The facility administrator and facility nurse confirmed the assessments were not completed prior to the residents' admission to the facility.
7	.320. NEGOTIATED SERVICE AGREEMENT (NSA) REQUIREMENTS.	A Negotiated Service Agreements (NSA) was not completed within 14 days of admission for Resident #10, who was admitted to the facility on 8/5/25. The administrator confirmed the NSA was not completed.
8	.320.08. Periodic Review.	NSAs were not updated to reflect significant changes for Resident #2 and Resident #9. Resident #2's NSA was not updated after a decline in health which resulted in the resident becoming bed bound and requiring a higher level of care for all needs, which included mobility, bathing, and toileting. Resident #9 did not have a current NSA, the most recent NSA available was dated 6/24/24. The facility administrator stated the NSAs had not been updated to reflect changes in condition or annual review.
9	.330.04.a. Behavior Documentation.	Facility staff documentation was not completed by the staff making observations. Several staff members stated the caregivers did not have access to the computer system and the medication technicians charted for them, including witnessing incidents or changes in status. The facility nurse, administrator, and the residential care coordinator (RCC) confirmed the medication technicians charted for the care staff.
10	.330.04.c.iii. Resident Care Records.	The facility medication technicians did not document the amount of insulin given for Resident #6 the entire month of August 2025 through the date of the survey. The facility nurse and administrator confirmed the insulin amounts were not documented. Documentation of communication between the medication technicians and the facility nurse when as needed (PRN) medications were given for cognitively impaired residents. For example, Resident #2 was given PRN acetaminophen, hydroxyzine, lorazepam, methocarbamol, morphine, oxycodone, and prochlorperazine. Several staff members stated they did not always call the nurse to get

		authorization for residents who could not speak for themselves and gave the medications if they thought the residents had pain or were agitated. The facility nurse stated she was not aware PRN medications were given without authorization by a nurse.
11	.330.04.c.vii. Resident Care Records.	The facility nurse did document changes of condition when Resident #2 had received staples to their scalp on 3/24/25, had a rash on 4/2/25, when they were admitted to hospice, and had a fall on 7/30/25. Resident #6 returned to the facility from the hospital on 5/7/25 after a hip fracture. Resident #6 also had falls on 6/12/25, 6/16/25, 7/7/25, 7/16/25, and 8/31/25 and the facility nurse did not document changes of condition. Resident #6 was seen in the emergency room on 6/19/25. Resident #9 was seen in the emergency room for a fall on 5/1/25. Resident #9 had falls on 4/22/25 and 9/6/25. The facility nurse stated the residents were assessed for these changes; however, the assessments were not documented.***Previously cited on 7/25/23.***
12	.330.06. Additional Resident Records.	The facility did not evaluate nor develop interventions for ongoing behaviors when Resident #10 raised their voice to threaten harm to other residents and repeatedly bumped their wheelchair into another resident, which were observed during the survey between 9/8/25 to 9/10/25. Staff confirmed Resident #10's behaviors had been ongoing and required redirection to prevent resident to resident altercations and staff stated they were informed a behavior plan was not required for this resident because they did not take any psychotropic medications. Several staff stated Resident #5 has been known to be combative and required consistent redirection and monitoring to stay out of other residents' rooms. Staff also stated Resident #5 took and/or moved other residents' wheelchairs or walkers. Resident #5 was observed during survey between 9/8/25 to 9/10/25, to attempt to exit the facility. Staff were observed on multiple occasions to

		provide multiple prompts and redirection to prevent Resident #5 from bothering other residents or exiting the facility. The administrator confirmed behavior plans for these residents were not developed.
13	.330.13. Personnel Records.	The facility did not maintain staff records with all required documentation. For example, one employee who transferred from a sister facility did not have any documentation at the facility and had to be requested from the sister facility when the surveyors requested it. Additionally, three of ten staff records did not contain documentation of multiple required components, such as orientation training, infection control training, and specialized training. Multiple staff stated they had received the various training prior to working with residents. The administrator stated the trainings were completed and were unable to provide the documentation when requested due to the documentation not being maintained at the facility.
14	.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.
15	.600.02. Detached Buildings or Units.	The facility did not ensure all buildings were staffed sufficiently to ensure one staff member was in each building at all times. For example, several staff members stated buildings were left unattended for short periods of time when they needed to "swap" a caregiver for a medication technician, because each of the four buildings only had one staff working in each building on night shift for several nights. The facility's as-worked schedules documented the facility only had four staff working to cover each building, and one or more of those staff were not delegated to pass medications. The administrator stated on nights when there was no float staff, medication technicians had to swap with a caregiver in order to pass medications.***Previously cited on 7/25/23.***
16	.600.04.a. Sufficient Personnel.	The facility did not schedule sufficient personnel during all

		hours to meet the needs of the residents. Multiple residents, family members, and staff members stated the facility did not have enough staff to always meet the needs of the residents. One family member stated besides their loved one, they would sometimes help other residents when they were in the facility because there were not enough staff, especially during the evening hours. On 9/10/25, building #2, which was a memory care unit with 13 residents, was observed with only one care staff on duty for several hours. The single care staff was observed to rush to provide assistance with various activities of daily living and struggled to keep up with assisting residents, including a resident who had fallen in the common area during the observation. The nurse and administrator confirmed there were not enough staff scheduled to meet the needs of the residents currently residing in the facility.
17	.645.02. Delegation.	Five of five staff, who passed medications, had delegations which were not done individually and did not include skill demonstration. The RN stated he did not conduct observations of skill demonstration. The administrator confirmed the delegations were not all done individually and did not include skill demonstration.***Previously cited on 7/25/23.***
18	39-3308 Assessment (4)b Assessments	The facility nurse did not implement all residents' orders. The facility nurse stated some orders were only reviewed by the the RCC prior to residents receiving medications.
19	39-3316 Resident Rights (2) Privacy	The facility failed to ensure residents' rights to privacy was protected. On 9/8/25 during the initial tour, Resident #8's room was observed to have two cameras in their room. There were no signs outside of the room to warn other residents, visitors, or staff they were being recorded. One camera was on a dresser which pointed towards the living room area and the second camera was angled in the corner of the room above the bed, which pointed towards Resident #8's opened bathroom door, where the toilet was visible. During the survey, Resident #8 stated they were aware their family had

		placed the cameras in their room and had no concerns with them being there. Resident #8 stated they would not agree to the cameras if they were watched by their family when they were on the toilet, and stated, "They wouldn't do that." Several staff stated they knew Resident #8's family members watched them provide cares to the resident, including toileting, because the resident's family talked through the cameras at times and told staff they were not providing cares appropriately at the time they were providing those cares. Resident #8's nurse's notes, dated 5/13/25, documented a conversation the facility nurse had with a family member where the family member told the nurse the family had witnessed Resident #8 use the toilet and could see the resident have a bowel movement along with urination. The progress notes documented on 5/15/25 the facility nurse, the administrator, and Resident #8's family member had a care conference where a third camera in the resident's bathroom, facing the toilet, was not allowed, and the family member agreed to remove the camera. The facility nurse stated she had concerns with lack of privacy for Resident #8 due to the cameras in Resident #8's room and bathroom. She stated after the care conference in May, the family member had taken down the camera in the bathroom, but had not asked the family if they could still see Resident #8 while on the toilet with the camera in the corner. The administrator stated they had not considered if the camera in the corner could allow the family members to observe Resident #8 while on the toilet.
20	39-3321.2.c. Qualifications and Requirements of Administrator.	The administrator did not ensure facility incidents were investigated. For example, Resident #9, experienced a fall on 4/22/25, a skin tear on 5/3/25, a fall on 9/5/25, and an emergency room visit on 9/6/25, and there was no investigation documented. Resident #8 experienced a fall on 5/13/25, and there was no investigation documented. Resident #6 had a fall on 7/16/25 and there was no

		investigation documented. The administrator stated there should have been an investigation completed for these incidents.
21	39-3321.2.d. Qualifications and Requirements of Administrator.	The facility did not develop interventions to prevent recurrences after residents' incidents. For example, Resident #6 experienced falls on 7/7/25 and 7/16/25 and no interventions were found in the record. Resident #9 had a fall on 9/5/25 and an emergency room visit on 9/6/25 and no interventions were found in the record. Resident #2, who had cognitive impairment, experienced 12 falls between 4/26/25 and 8/5/25, and the corrective action was the same for each incident to "remind and orient resident to call light", which was not an effective intervention due to their repeated falls. The facility administrator acknowledged the interventions were not completed.