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
Vauny Robb	Coeur d' Alene	83815	02/02/2026
Survey Team Leader	Survey Type		Response Due
Walker, Jenny	Health Care Licensure and Follow-Up		03/04/2026

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 and title 39 and chapter 33. The facility did not receive sufficient support from the Licensee which resulted in multiple non-core deficiencies during the survey and the facility receiving repeat non-core deficiencies at: 001.03 for the licensee not providing necessary resources to the facility, 009.01 for not having staff complete criminal history background checks before working alone with residents, 260.06 for not providing a clean and safe living environment for residents, 260.07 for not securing toxic chemicals, 305.02.b for not providing residents with their medications as ordered, 305.03 for not completing change of condition assessments, 310.01.c for not monitoring and documenting medication refrigerator temperatures daily, 310.01.g for not having residents' as-needed (PRN) medications available, 310.04.e for not conducting six-month psychotropic medication reviews, 319 for not completing pre-admission assessments, 320.01 for Negotiated Service Agreements (NSAs) updated to reflect residents' current needs, 330.06.a for not evaluating maladaptive behaviors, 335.02 for not following infection

		control standards, 403 for not meeting various fire life safety requirements, 405.04 for not conducting fuel fired inspections, 450 for failed kitchen inspections, including a failed follow-up kitchen inspection on 1/30/26 from the original failed inspection on 1/27/26, and 600.02 for staff leaving the buildings unattended. An outside provider stated the facility management and staff had not been supported by the corporation to keep the facility in compliance. The department heads, including the administrator stated they had very little, if any support and training from the corporation. The facility nurse stated she had learned more about the rules from the survey team in two days than she had ever learned from corporate staff. The facility administrator stated she had to pay for employee Idaho State Police background checks with her own credit card because her corporate card had exceeded the limit.***Previously cited on 8/23/24***
2	.009.01. Criminal History and Background Check.	Five of fifteen employees, whose personnel records were reviewed, did not have a Department Criminal History and Background Check completed. Upon interview with the administrator, it was confirmed the Department Criminal History and Background Checks were not completed. ***Previously cited on 8/23/24***
3	.009.02.b. Scope of a Criminal History and Background Check.	Twelve of twelve 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.
4	.250.09. Resident Sleeping Rooms.	The water temperatures in the facility were not maintained between 105 to 120 degrees F. For example: The temperature in the Pine building ranged between 98 degrees F and 130 degrees F. The temperature in the Cedar building ranged between 95 degrees F and 130 degrees F. The temperature in the Oak building was as high as 122 degrees F. The

		administrator stated she had the maintenance supervisor try to adjust the temperatures.
5	.250.13. Secure Environment.	The facility failed to provide a secured environment for Resident #13, who was cognitively impaired and was a risk for elopement, and was residing in the Cedar building, which was unsecured. Resident #13's NSA, dated 8/12/25, documented, "CAN RESIDENT LEAVE THE PREMISES UNASSISTED? NO." Several staff stated when the resident attempted to go out, they redirected them. They stated the resident could not go outside alone and would not be safe to leave the facility. They stated they "keep an eye on [them] if [they] try to go out," or go out with them to ensure they were safe. The staff stated the resident could not go outside. Resident #13 was interviewed and was unable to state where they resided or details of their personal history. Resident #13 was observed walking around the common area saying, "What should I be doing?" They were also observed to attempt to open the door leading outside and was immediately redirected by staff. The facility nurse stated she was not sure if Resident #13 was safe to leave the facility alone. The facility administrator stated she didn't know if Resident #13 was safe to leave the facility alone.
6	.260.06. Toxic Chemicals.	The facility was not maintained in a clean, safe, and orderly manner. For example, the Cedar building's doors, door jambs, baseboards, and walls were observed to be scratched, gouged, and blackened throughout the building. Bathrooms throughout the building were observed to be soiled with urine and feces on the walls, floors, and toilet bases. For example, room C4 had a large amount brown substance spattered on the baseboards, walls, and around the base of the toilet. A large amount of debris was observed along baseboards of bathroom floors and floor vents. Rooms #3 and #4 had a strong odor of urine, which could be detected in the hallway. In the Pine building the sofa set in the common area was soaked with urine to the degree that urine soaked through clothing when

		sat on, and there were urine odors in the common area. In the Cedar kitchen all cupboards and draws were observed to have deep scratches and chips, broken cupboards, including the cupboard doors under the prep sink, a pull knob on one cupboard was missing. Several cupboards, the front of the refrigerator and the one outlet plate was soiled. The facility manager stated she was unaware of the furniture in the Pine building. She stated she was aware of the Cedar building cabinetry in the Cedar building and was hoping to get them replaced.***Previously cited on 8/23/24***
7	.260.07. Toxic Chemicals.	Toxic chemicals were observed to be stored in unlocked cabinets and on the countertop in the Oak building's laundry room, which had a keypad lock, but was not utilized nor engaged. Both toilet bowl cleaner and Comet were accessible to cognitively impaired residents on three different occasions between 1/27/26 to 1/29/26. The Cedar building laundry room door had a keypad lock, which was inoperable and the door did not lock, and chemicals including bleach, toilet bowl cleaner, and all-purpose spray were observed to be unsecured and accessible to residents with cognitive impairment on three separate occasions between 1/27/25 and 1/29/25. The facility administrator stated she was unaware of the unsecured chemicals.***Previously cited on 8/23/24***
8	.305.02.b. Quarterly Nursing Assessments.	Residents did not receive medications as ordered. For example, Resident #7 had been receiving metoprolol succinate when metoprolol tartrate was ordered since 4/14/25. Nystatin powder was ordered two times daily, however staff stated they sometimes applied it another time if the resident's skin was red. An unsampled resident had levothyroxine ordered to be given on an empty stomach and was given the medication with breakfast. Staff stated they gave the medication in the morning with other meds and sometimes after the resident had eaten breakfast. Resident #5 did not receive their Zenpep twice, amiodarone three times, and trazodone three times in

		November 2025, nor their escitalopram four times in January 2026. Resident #10 did not receive their pregabalin five times in December 2025. The facility nurse stated staff did not always check to see if the medications were in the Spruce building where medications were delivered. The facility nurse also stated she was not aware the unsampled resident was receiving their levothyroxine incorrectly. ***Previously cited on 8/23/24 and 1/29/25.***
9	.305.03. Change in Resident Health Status.	The facility nurse did not assess residents after they experienced changes in their health status. Seven of thirteen sampled residents were not assessed after changes in their condition. For example: Resident #1 eloped on 10/27/25. Resident #3 experienced a fall on 7/29/25. Resident #6 was not assessed for a change in condition after 31 falls between 5/26/25 and 1/24/26. Resident #7 had persistent yeast infections documented by staff between 4/15/25 and 7/28/25, and on 12/28/25 had a painful, bleeding rash under their pannus. Resident #8 was in the hospital due to pneumonia in September 2025 and when staff documented the resident was 'really struggling', had been taking Mucinex and their inhaler every 4 hours. Resident #12 was involved in resident to resident altercations on 8/29/25 and 9/8/25, and had a medical incident and was sent to the emergency room on 1/21/26. The facility nurse stated she did not complete the change of condition assessments. ***Previously cited on 8/23/24***
10	.310.01.c. Medication Distribution.	The facility's medication refrigerator temperatures were not monitored and documented daily. For example, the Oak building temperature logs were not monitored and documented 21 out of 29 days in January 2026. The Pine building temperature logs were not monitored and documented 14 out of 26 days in January 2026. The Spruce building temperature logs were not monitored and documented 25 out of 31 days in December 2025 and 6 of 29

		days in January 2026. The facility nurse stated they were unable to obtain November and December 2025 medication temperature logs for Cedar, Oak, and Pine. The facility nurse stated the medication refrigerator temperature logs were not completed daily. ***Previously cited on 8/23/24***
11	.310.01.g. Medication Distribution System.	Four of thirteen sampled residents did not have their PRN medications available in the facility. For example, Resident #3 did not have their PRN migraine medication nor their mouthwash available in the facility. Resident #4 did not have their PRN hydromorphone, nor their milk of magnesia available in the facility. Resident #9 did not have their PRN milk of magnesia available in the facility. Resident #5 did not have their PRN ondansetron available in the facility. The facility nurse stated she was unaware PRNs were not available for the residents. ***Previously cited on 8/23/24***
12	.310.02.d. Discontinued and Expired Prescriptions.	The documentation for medication destruction was incomplete. The facility failed to maintain medication destruction records which included the method of destruction for multiple residents' medications for December 2025 and January 2026. A written record of all drug disposals including method of disposal must be maintained in the facility. The facility nurse confirmed the current record did not include method of destruction.
13	.310.04.e. Psychotropic or Behavior Modifying Medication.	Resident #4 was taking escitalopram, olanzapine, haloperidol, and lorazepam and the last six month psychotropic medication were reviewed on 6/3/25. Resident #9 was taking duloxetine, olanzapine, and paliperidone and the six month psychotropic medication review dated 12/26/25, did not include behavioral updates. The administrator stated they were not completed. ***Previously cited on 8/23/24***
14	.319. COMPREHENSIVE ASSESSMENT REQUIREMENTS.	Resident #3 did not have demographics, nursing, and maladaptive behaviors assessed prior to being admitted on 10/17/25. Residents #1, #2, #3, #7, #8, #9, #10, #11, and #12,

		did not have a nursing assessment prior to being admitted to the facility. The facility nurse stated she was unaware she had to complete the nursing assessment prior to the residents being admitted to the facility. ***Previously cited on 8/23/24***
15	.320.01. Use of NSA.	Residents' NSAs did not clearly reflect the residents' needs nor describe the services to be provided. For example, Resident #1, who was admitted to the facility on 10/27/25, did not have an NSA in place at the time of the survey, Resident #12's NSA documented they were independent with transfers when they required stand by assistance with transfers. Resident #8 had a prosthetic leg and a brace to the other leg, which required cleaning and monitoring of skin. The facility nurse stated the residents' NSAs needed to be updated. ***Previously cited on 8/23/24***
16	.320.02. Key Elements of the NSA.	The NSA for 10 of 13 sampled residents did not include all of the required components. For example, Resident #2 and #9s' NSAs did not contain information regarding night needs, money management, outside services, or emergency evacuation. Resident #5 and #10s' NSAs did not contain information regarding night needs, money management, or emergency evacuation. Resident #4's NSA did not contain behaviors, night needs, or money management. The facility administrator stated the facility nurse was responsible to complete the NSAs. The facility nurse stated she was unaware the NSAs were missing necessary components.
17	.320.03. Signature, Date, and Approval of Agreement.	NSAs were not signed and dated by Residents #3, #7, #8, #10, and #12, nor their legal guardians. The facility nurse stated they were not signed by the legal guardians.
18	.330.04. Behavior Documentation.	Residents' care records were not maintained for each resident in their individual records. For example, the shift change notes were observed to have multiple residents' information on the same page. The facility nurse stated she was unaware the notes needed to be seperated and placed in each resident's

		record.
19	.330.04.c.vi. Resident Care Records.	The facility staff did not notify the facility nurse when residents had a change of condition. For example, the nurse was not notified between 4/15/25 and 6/4/25 when medication technicians documented yeast infections for Resident #7 which were spreading, and skin sloughing off of their legs. On 12/28/25, staff documented the resident had a small cut on their toe. The resident also frequently refused medications and care. The staff stated they only notified the nurse if they felt it was "significant" and would "just take care of it themselves." The facility nurse stated the staff didn't always notify her of changes in condition of residents.
20	.330.06.a. Additional Resident Records.	The facility did not assess residents' maladaptive behaviors. For example, Resident #7 frequently refused medications, care such as showers, refusing to allow staff to clean their room, using paper towels to dry the floor rubbing the urine-soaked paper towels on their feet. Resident #8 went to the store to buy wine, for which there was no provider order, had been observed to be smoking in their room on several occasions, and watching inappropriate things on their phone in areas where other residents could hear, which made them uncomfortable. Resident #8 also had been observed giving cigarettes to other residents, and frequently refused to allow staff to assist with changing their briefs when soaked with urine or cleaning their prosthesis. The facility nurse confirmed the residents were not assessed for these behaviors.***Previously cited on 8/23/24***
21	.330.06.b. Additional Resident Records.	The facility did not develop behavior plans which included specific interventions for Residents #7 and #8 who engaged in maladaptive behaviors. See examples in non-core deficiency 330.06.a. The facility nurse and administrator confirmed the facility had not developed the behavior plans. ***Previously cited on 8/23/24***
22	.330.06.c. Behavior Documentation.	The facility did not track maladaptive behaviors, including

		time, date, and description of maladaptive behaviors, nor effectiveness of interventions as described in deficiency 330.06a. Additionally, staff did not document the effectiveness of interventions when Resident #12 was involved in two resident to resident altercations on 8/29/25 and 9/8/25, went into other residents' rooms on 8/18/25 and 8/24/25, and punched a visitor in the face and kicked staff on 12/3/25. The facility nurse stated not all of the necessary components of behavior tracking were documented by staff.
23	.330.15.c. Fire and Life Safety Records.	Based on record review and observation of fire extinguisher monthly tags; the facility failed to document the monthly visual inspection of all portable fire extinguishers in all five buildings, (Cedar, Fir, Oak, Pine, and Spruce). The maintenance supervisor confirmed they were not completed on a monthly basis.
24	.335.02. Standard Precautions.	The facility did not follow standard infection control procedures. For example, in the Oak building, there were no paper towels in the shared bathroom in between rooms #1 and #2, #7 and #8, and #13 and #14, there was a soiled toilet scrub brush resting on the counter next to the sink in the shared bathroom in between rooms #3 and #4. In the Oak building, the cook was observed to rinse their gloves rather than their hands and other staff were observed not wearing aprons in the kitchen after providing cares to residents. In the Cedar building, a food ladle was dropped on the ground and was rinsed with water only and then placed back into service. A cake spatula was used in the Spruce building, placed on top of the exposed food cart, and then carted to the other three houses where it was used there as well. The administrator stated the facility was working on improving infection control procedures. ***Previously cited on 1/29/25***
25	.403. FIRE AND LIFE SAFETY STANDARDS FOR EXISTING BUILDINGS LICENSED FOR THREE THROUGH SIXTEEN RESIDENTS.	1. The facility failed to obtain an annual inspection of the fire alarm system. The previous inspection was conducted on 3/12/24, for Cedar, Fir, Oak, and Pine buildings, with a gap of

		over fourteen months since the previous inspection. The maintenance supervisor stated the inspections had not been completed. 2. The facility failed to obtain a 5-year obstruction inspection buildings: Fir, Oak, and Pine. The maintenance supervisor was unable to obtain the 5 year obstruction inspection for each of the buildings. 3.The facility did not have the kitchen hood suppression system inspected every six months in buildings: Fir and Spruce. The maintenance supervisor stated the inspections were not completed. 4. The facility did not have the kitchen hood cleaned every six months in buildings: Fir and Spruce. The head cook stated the kitchen hoods had never been cleaned.***Previously cited on 3/7/24***
26	.405.04. Prohibited Applications.	The facility has a gas fireplace located in the barn and each of the five buildings; Cedar, Oak, Fir, Pine, and Spruce. The fuel fired heating inspection/testing was last inspected 1/15/25, however, the inspection did not include which building was inspected. All fuel-fuel fired heating devices shall be inspected. ***Previously cited on 3/7/24***
27	.410. REQUIREMENTS FOR EMERGENCY ACTIONS AND FIRE DRILLS.	The facility failed to conduct fire drills in accordance with rule. The facility's fire drill documentation showed Oak and Cedar buildings ran a fire drill on 1/19/26 but Pine and Spruce were not included. On 10/29/25, a fire drill was documented for one building but it did not document which one. On 8/14/25, three fire drills were documented but did not document which buildings. The maintenance supervisor confirmed the fire drills were not consistently conducted.
28	.450. REQUIREMENTS FOR FOOD AND NUTRITIONAL CARE SERVICES.	The facility did not meet the standards for the Idaho Food Code. Kitchen inspection failed twice, once on 1/27/26 and

		another time on 1/30/26. Mandatory re-inspection was required again, within 10 days. ***Previously cited on 8/23/24***
29	.451.01.d. Menu.	The facility did not serve the planned menu. For example, on 1/26/26, the menu documented lentil soup, cheese tortellini with basil pesto sauce, and breadstick were to be served and macaroni and cheese, tomato soup, and crackers were served, and on 1/27/26, dixie cornbread casserole was to be served and shipwrecked casserole was served instead, and on 1/28/26, fresh apples were to be served and no fruit at all was served. The kitchen manager stated often times he did not have the specific foods on hand to serve the planned menu. ***Previously cited on 8/23/24***
30	.460.02.d. Frequency of Meals.	Snacks were not offered between meals or at bedtime. Oak building staff stated snacks were not given to residents throughout the day unless residents requested them. Snacks were not provided in Pine building, Spruce building, or Cedar building between meals. The facility administrator stated she was unaware that snacks were supposed to be offered three times a day.
31	.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 family members and multiple staff members stated buildings were left unattended for short periods of time when they "switched" between buildings, particularly when one building did not have a medication technician and a medication technician had to leave one building to pass medications in another building, or when residents who exhibited maladaptive behaviors which required more than one staff member to manage their behaviors, or when a resident required two person assistance. On 1/28/26 and 1/29/26, the medication technician was observed leaving the Spruce building unattended for short periods of time. The as-worked night shift schedule for 1/26/26, documented two

		caregivers and one medication technician, and one caregiver that called in, leaving one building unattended, and only one medication technician to pass medications to buildings: Cedar, Oak, and Pine. On 1/27/26, the as-worked night shift schedule documented three medication technicians and one caregiver were assigned to cover the four buildings with the caregiver in the Pine building, so staff had to leave two of the buildings unattended to "switch" buildings. The facility nurse stated they were trying to schedule a float for the night shift, but it did not always happen and sometimes the staff "switched" leaving a building unattended for short periods of time. ***Previously cited on 1/29/25***
32	.600.04.b. Sufficient Personnel.	Five of fifteen employees, who required it and worked alone, did not have current CPR and First Aid certificates. Additionally, four of fifteen employees, who required it and worked alone, did not have current First Aid Certificates. The administrator confirmed the employees did not have current certificates and they worked alone.
33	.625.01. Number of Hours of Training.	Fifteen of fifteen staff, whose records were reviewed, did not contain documentation of 16 hours of orientation training. The administrator stated she could not locate the contents of the orientation training for nine of the staff and the other six staff did not complete the orientation training.
34	39-3308 Assessment (4)a Assessments	The facility did not ensure 90-day assessments were completed once every 90 days by a licensed nurse for 8 of 13 sampled residents. For example, Resident #9 did not have a 90-day assessment completed from admission date on 4/29/25 to current. Resident #10 did not have a 90-day assessment completed from admission date on 9/12/25 to current. Resident #5 did not have a 90-day assessment completed from admission date on 9/20/25 to current. Resident #3 did not have a 90-day assessment completed from admission date on 6/12/25 to current. Resident #4 did not have a 90-day assessment completed since November 2024. Resident #12 did

		not have a 90-day nursing assessment completed from admission on 8/8/25 to current. The facility nurse confirmed the 90-day assessments were not completed.
35	39-3316 Resident Rights (2) Privacy	The facility did not provide a private area or portable phone for residents to make phone calls in the Cedar building. A resident was observed making a phone call on a corded phone in the common area where other residents and staff could hear their conversation. The resident stated they were uncomfortable talking on the phone in front of other residents and staff did not provided a private area or portable phone. Staff stated the identified resident called their loved one and they could hear their conversation. The facility nurse stated she was not aware the phone was not private. The administrator stated she did not know the rule regarding telephone privacy.
36	39-3316 Resident Rights (3) a.i. Humane care and environment	The facility failed to protect residents' rights and provide a humane environment for residents. For example, during the tour on 1/26/26 in the Pine secured memory care unit, Resident #10 stated they were cognitively intact and had been stuck in a secured unit since they were admitted to the facility on 9/12/25. They stated when they admitted there were no beds available in the assisted living building and had been agreeable to move into the secured unit, however they had since become tired of some of the residents displaying dementia type behaviors like walking into the common area naked or knocking on their door in the middle of the night. They stated due to the other residents' behaviors, they had begun to self-isolate in their room, except when eating meals. They stated they were also a lot younger than all of the residents in the secured unit. Multiple staff stated Resident #10 was cognitively intact and were not sure why they were in the secured unit. Resident #10 was admitted on 9/12/25, and their physician orders and pre-admission assessment documented they had no cognitive impairment. The facility

		nurse stated she was told by the former sales staff Resident #10 belonged in the secured unit. The facility nurse stated she had since assessed Resident #10 and determined they were not appropriate for a secured environment. The administrator stated the former sales marketer had told her Resident #10 had cognitive impairment and the former administrator had admitted the resident into the secured unit.
37	39-3316A .4. Notice of Resident's Rights	The facility failed to post the residents' rights in the facility at all times. For example, the Pine and Spruce buildings were observed and there were no residents' rights posted in the buildings. Resident #10 (see 39-3316.3a) resided in the Pine building and did not have visual access to their rights as the building lacked the posting. The administrator stated she was not sure why the buildings did not contain the residents' rights posting.
38	39-3321.1. Qualifications and Requirements of Administrator.	The facility operated without a licensed administrator from 11/15/25 through 11/23/25. According to a communication in the Facility Licensing and Regulatory Enforcement System portal, the previous administrator's last day was 11/14/25, and there was a lapse of nine days before a provisional administrator started on 11/24/25.
39	39-3321.2.d. Qualifications and Requirements of Administrator.	The facility did not identify and monitor patterns of accidents and incidents nor develop interventions to prevent recurrences. The administrator stated she did not monitor or track patterns of incidents.
40	39-3321.2.e. Qualifications and Requirements of Administrator.	The administrator did not complete an investigation and written report within 30 days of each incident and accident. For example, Resident #6 had a total of 28 documented falls between 5/26/25 and 12/26/26 and 22 of the falls were not investigated. Resident #1 eloped on 10/27/25, Resident #12 was involved in resident to resident altercations on 8/29/25 and 9/8/25, and Resident #9 had a fall on 1/22/26. The administrator stated not all of the incidents were investigated.
41	39-3321.4. Qualifications and Requirements of Administrator.	The administrator did not immediately implement corrective

		action to ensure incidents and accidents did not recur. For example, Resident #6 had a total of 37 documented falls between 5/26/25 and 1/24/26 and no corrective action was documented for 31 of the 37 falls. Resident #1 eloped on 10/27/25. Resident #3 experienced a fall on 7/29/25. Resident #5 experienced falls on 9/22/25, 9/23/25, and 1/18/26. Resident #11 experienced a fall on 1/21/26. Resident #12 was involved in two resident to resident altercations on 8/29/25 and 9/8/25. The facility nurse stated the corrective actions were not always implemented.
42	39-3321.5. Qualifications and Requirements of Administrator.	The facility did not notify licensing and certification (L&C) within one business day when Resident #5 fell on 9/23/25 and 1/18/26, and was sent to the hospital for evaluation. The administrator confirmed L&C was not notified of these incidents.