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
Trudie Chamberlain	Coeur d' Alene	83815	03/27/2026
Survey Team Leader	Survey Type		Response Due
Walker, Jenny	Health Care Non-Core Deficiency Follow-Up		04/26/2026

Item #	Rule (16.03.22)	Description
1	.001.03. General Provider Responsibilities.	The Licensee failed to provide necessary resources to ensure the facility operated consistently within 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 repeat non-core deficiencies during the follow-up survey as follows: 001.03 (3rd repeat) for the licensee not providing necessary resources to the facility, 009.02.b for employees not having an Idaho State Police Background check completed before working alone with residents, 250.09 (3rd repeat) for water temperatures not maintained between 105 and 120 degrees Fahrenheit, 260.06 (3rd repeat) for not providing a clean and safe living environment for residents, 305.02.b (4th repeat) for not providing residents with their medications as ordered, 305.03 (3rd repeat) for not completing change of condition assessments, 310.01.c (3rd repeat) for not monitoring and documenting medication refrigerator temperatures daily, 310.01.g (3rd repeat) for not having residents' as-needed (PRN) medications available, 310.04.e (3rd repeat) for not conducting six-month psychotropic medication reviews, 320.01 (3rd repeat) for Negotiated Service Agreements (NSAs) not updated to reflect

		residents' current needs, 320.02 for not including key elements for the NSA, 320.03 for not having the NSAs signed and dated by the facility, resident and/or legal guardian, 330.04.c.vi for staff not notifying the facility nurse when residents experienced a change of condition, 335.02 (3rd repeat) for not following infection control standards, 403 (3rd repeat) for not completing annual fire alarm inspections, 450 (3rd repeat) for a failed kitchen inspection on 3/24/26, 451.01.d (3rd repeat) for not serving the planned menu, 600.02 (3rd repeat) for staff leaving the buildings unattended, 600.04.b for direct care staff who worked alone without a current CPR and First Aid certificates, 39-3308 for not completing 90 day assessments, 39-3316 for not providing a private area or portable phone for residents, 39-3321.2.d for not monitoring patterns of accidents and incidents, and 39-3321.5 for not reporting Licensing and Certification (L&C) of incidents. The facility had not been supported by the corporation to keep the facility in compliance. ***Previously cited on 8/23/24 and 2/2/26***
2	.009.02.b. Scope of a Criminal History and Background Check.	Two of two employees, whose personnel records were reviewed and required an Idaho State Police Background Check, did not have an Idaho State Police Background Check completed and were working alone unsupervised. The business office manager confirmed the Idaho State Police Background Checks were not completed. ***Previously cited on 2/2/26***
3	.250.09. Resident Sleeping Rooms.	The water temperatures in the facility were not maintained between 105 to 120 degrees F. For example, the water temperatures in the Pine building ranged from 85 F and 103 F in resident bathrooms and shower rooms. The water temperatures in the Oak building were found to be between 101 F and 103 F. In the Spruce building the water temperature in room #102 was 92 degrees F. The administrator acknowledged the water temperatures were outside the range 105 to 120 degrees F.

		Previously cited on 8/23/24 and 2/02/26
4	.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. The top of the baseboard around the dining room counter was observed to have a large amount of dust. The flooring of multiple bathrooms were observed to be soiled around the toilet bases. A large amount of debris was observed along baseboards of bathroom floors and floor vents. In the Cedar kitchen, all cupboards and drawers were observed to have deep scratches and chips, broken cupboards, including the cupboard doors under the prep sink, and a pull knob on one cupboard was missing. Several cupboards, the front of the refrigerator, and the one outlet plate were soiled. Multiple cigarette butts were observed along the sidewalk in front of the Cedar building. Several sections of a loose countertop were observed outside the Ponderosa building. In the Fir building, multiple room doors were missing door knobs and one room door was missing from the hinges. The maintenance supervisor stated they were aware of the housekeeping needs and were working on it. ***Previously cited on 8/23/24 and 2/2/26***
5	.305.02.b. Quarterly Nursing Assessments.	Residents did not receive their medications as ordered. For example, Resident #2 did not receive their gabapentin daily between 3/15/26 and 3/19/26 as they were not available for staff to administer. Resident #3 had an order for oxygen at two liters/minute continuously and was receiving three liters/minute from 3/4/26 to 3/25/26, they also did not receive any of their routine medications on 3/21/26; Resident #4 did not receive the following medications as they were not in the medication cart: Topiramate three times in March 2026, Mirtazapine ten times in March 2026, Ketoconazole 2% shampoo four times in March 2026, and Duloxetine HCL one time in March 2026; Resident #7 did not receive their Lisinopril

		three times in March 2026 nor their Citalopram, Finasteride, Gabapentin, Diclofenac sodium, Olanzapine, Lisinopril, Quetiapine Fumarate, Polyethylene glycol, and Valacyclovir HCL on 3/18/26; Resident #9 did not receive their Milk of Magnesia 22 times in March 2026; Resident #10 was ordered to have 30 units of Lantus in the morning and 30 units of Lantus in the evening, but received 35 units of Lantus in the morning and 30 units of Lantus in the evening; and Resident #11 had an order on 3/5/26 for ondansetron twice daily as needed and was receiving it routinely twice a day. ***Previously cited on 8/23/24, 1/29/25, and 2/2/26***
6	.305.03. Change in Resident Health Status.	The facility nurse did not assess eight of twelve sampled residents after they experienced changes in their health status. For example: Resident #12 became very aggressive by hitting a staff member resulting with a fractured wrist on 3/22/26. Resident #1 had a broken top incisor on 3/8/26. Resident #11 had refused their ondansetron medication eight times from 3/4/26 to 3/23/26. Resident #3 experienced low oxygen levels and required oxygen and had a sore on their right great toe on 3/4/26 and was started on antibiotics on 3/6/26. Resident #5 had increased behaviors on 3/9/26 and was started on psychotropic medications on 3/17/26. Resident #7 experienced a fall on 3/20/26. Resident #9 experienced a fall on 3/11/26. Resident #6 experienced a fall on 3/8/26 and EMS evaluated the resident and experienced a fall on 3/19/26. Resident #10 was sent to the hospital on 3/17/26, for vomiting and lethargy. The administrator stated they did not have a licensed nurse available to assess the residents who experienced a change in their health status. *** Previously cited on 8/23/24 and 2/2/26***
7	.310.01.c. Medication Distribution.	The facility's medication refrigerator temperatures were not consistently monitored and documented daily, nor were the temperatures maintained between 38 and 45 degrees F. For example, the medication refrigerator temperature in the Cedar

		building was out of range 15 times, as low as 35 degrees F, from 3/4/26 to 3/23/26; the medication refrigerator temperature in the Spruce building was 37 degrees F every day between 3/4/26 and 3/23/26, and in the Oak building the medication refrigerator temperature was out of range eight days from 3/4/26 and 3/23/26, and as low as 34 degrees F. The administrator stated she was not aware the refrigerator temperatures were not monitored daily or out of range. ***Previously cited on 8/23/24 and 2/2/26***
8	.310.01.g. Medication Distribution System.	Residents #3 and #6 did not have their PRN acetaminophen available to them in the facility. Resident #4 did not have their acetaminophen nor their milk of magnesia available in the facility. Resident #5 did not have their quetiapine, Resident #8 did not have their haloperidol, and Resident #12 did not have their bisacodyl as ordered by their provider in the facility. The facility administrator acknowledged they were not in the facility. ***Previously cited on 8/23/24 and 2/2/26***
9	.310.04.e. Psychotropic or Behavior Modifying Medication.	Resident #2 was taking escitalopram, Resident #3 was taking duloxetine and escitalopram, and Resident #4 was taking mirtazapine and olanzapine and did not have a six-month psychotropic medication review completed. The administrator acknowledged they were not completed. ***Previously cited on 8/23/24 and 2/02/26***
10	.320.01. Use of NSA.	Residents' NSAs did not clearly reflect the residents' needs nor describe the services to be provided. For example, Resident #6's NSA did not reflect they had a private duty caregiver five days per week, eight hours a day to provide personal care. Resident #2's NSA did not reflect they had an outside agency providing physical therapy. Resident #3's NSA did not document which home health provider was working with them and when and how often and how often night needs were to be provided. Resident #7's NSA documented they were independent with ambulation when they required the use of a wheelchair. Resident #8's NSA documented they were

		independent with grooming, dressing, and toileting when they required assistance for these tasks. Resident #12's NSA did not document they had an outside hospice agency, nor what their role was. ***Previously cited on 8/23/24 and 2/2/26***
11	.320.02. Key Elements of the NSA.	Nine of twelve sampled residents' NSAs did not contain all of the required components. For example, Resident #1's, #4's, #7's and #12's NSAs did not contain information regarding their night needs. Resident #2's NSA did not contain information regarding their night needs and housekeeping services. Resident #5's NSA did not contain information regarding their laundry services. Resident #8's NSA did not indicate their supervision needs. Resident #10's NSA did not include night needs and the outside service they were receiving. Resident #11's NSA did not document what housekeeping services they were being provided. The administrator acknowledged the NSA was missing components. ***Previously cited on 2/02/26***
12	.320.03. Signature, Date, and Approval of Agreement.	NSAs were not signed and dated by Residents or their legal guardians. For example, Resident #11's NSA was not signed by the resident after they admitted to the facility on 1/31/26. Residents #3, #4, #7, #8, #9, and #12's NSAs were not dated nor signed by the resident or their legal guardians. The administrator acknowledged they were not signed. ***Previously cited on 2/02/26***
13	.330.04.c.vi. Resident Care Records.	The facility staff did not notify the facility nurse when residents had a change of condition. See examples in 305.03. The administrator and the regional administrator stated they were in the process of hiring a licensed nurse. ***Previously cited on 2/2/26***
14	.335.02. Standard Precautions.	The facility did not follow standard infection control procedures. For example, on 3/25/26, a medication technician was observed to pass medications to multiple residents' without performing hand hygiene between passes. The

		administrator stated the staff needed more training. ***Previously cited on 1/29/25 and 2/2/26***
15	.403. FIRE AND LIFE SAFETY STANDARDS FOR EXISTING BUILDINGS LICENSED FOR THREE THROUGH SIXTEEN RESIDENTS.	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 annual fire alarm system had not been completed. ***Previously cited on 3/7/24 and 2/2/26***
16	.450. REQUIREMENTS FOR FOOD AND NUTRITIONAL CARE SERVICES.	The facility did not meet the standards for the Idaho Food Code. The kitchen inspection failed on 3/24/26. Mandatory re-inspection was required within 10 days. ***Previously cited on 8/23/24 and 2/2/26***
17	.451.01.d. Menu.	The facility did not serve the planned menu. For example, on 3/23/26, the menu documented hot dog, french fries, marinated tomato and onion salad, and devil's food cake were to be served, and hot dog, french fries, green salad, and devil's food cake were served in the Oak building. On 3/24/26, the menu documented breakfast bake, bacon, grapes, toast, and oatmeal were to be served, and scrambled eggs, bacon, bananas, toast, and oatmeal were served in the Oak building. On 3/27/26, the menu documented oatmeal, grapes, sausage, waffle, and syrup were to be served, and oatmeal, sausage (after being alerted by surveyors), waffle and syrup were served in the Oak building. Multiple staff stated the facility did not have recipes to follow, therefore, could not follow the planned menu. ***Previously cited on 8/23/24 and 2/2/26***
18	.600.02. Detached Buildings or Units.	The facility did not ensure all buildings were staffed sufficiently to ensure at least one staff member was in each building at all times. For example, multiple staff members stated buildings were left unattended for short periods of time when they "swapped" 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. The as-worked night shift schedule for 3/22/26, documented two caregivers, one medication technician, and one new hire caregiver who shadowed a staff, were assigned to cover four buildings. This left one of the four buildings without a staff member during the entire night shift. The administrator was made aware and stated they were working on hiring staff. ***Previously cited on 1/29/25 and 2/2/26***
19	.600.04.b. Sufficient Personnel.	Five of thirteen employees, who required it and worked alone, did not have current CPR and First Aid certificates. Additionally, two of fifteen employees, who required it and worked alone, did not have current First Aid certificates. The Residential Care Coordinator confirmed the employees did not have current certificates and they worked alone. ***Previously cited on 2/2/26***
20	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 example, Resident #1 had a 90-day nursing assessment that was due on 3/8/26 and was not completed, Resident #2 had a 90-day nursing assessment that was due on 2/22/26 and was not completed, Resident #4 had a 90-day assessment that was due on 3/26/26, and was not completed, Resident #5 did not have a 90-day nursing assessment completed at all, and Resident #7's last 90-day nursing assessment completed on 12/31/25, and did not contain any nursing/medical information. The administrator stated the facility was working on hiring a facility nurse to assist in completing 90-day nursing assessments. ***Previously cited on 2/2/26***
21	39-3316 Resident Rights (2) Privacy	The facility failed to protect residents' rights and provide a private area or portable telephone in the Cedar building. A corded phone was observed to be in the common area. Several staff confirmed a private area or portable phone was not

		available for residents to make phone calls. ***Previously cited on 2/2/26***
22	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 they were not completed. ***Previously cited on 2/2/26***
23	39-3321.5. Qualifications and Requirements of Administrator.	The facility did not notify L&C within one business day when Resident #6 fell on 3/8/26 and an outside service evaluated the resident. The administrator and regional administrator confirmed L&C was not notified of this incident. ***Previously cited on 2/2/26***