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
Carly Frantz	Post Falls	83854	06/29/2026
Survey Team Leader	Survey Type		Response Due
Bollinger, Torrey	Health Care Complaint Investigation		07/29/2026

Item #	Rule (16.03.22)	Description
1	.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 #6 experienced right hip pain related to two falls on 2/20/26 and received x-rays results on 2/27/26 which showed Resident #6 had a fractured right hip. Resident #2 experienced homicidal and suicidal ideation on 5/7/26, 5/30/26, 6/11/26, and 6/22/26. Resident #1 exhibited multiple behaviors of hitting staff and residents from 4/16/26 through 6/5/26. One of the facility nurses stated she did not assess Residents #1, #2, and #6 after they experienced changes in condition.
2	.320.01. Use of NSA.	The facility did not coordinate Resident #6's needs when the Negotiated Service Agreements (NSAs) did not clearly reflect their needs nor describe the services to be provided. For example, Resident #6 fell on 2/20/26 which ultimately resulted in a fractured hip. The resident was assessed by an outside agency nurse on 2/21/26, 2/22/25, 2/23/26, 2/25/26, and 2/26/26. Outside agency notes from this timeframe documented the resident required additional assistance with their Daily Living Skills such as requiring two people to safely

		assist them to transfer. Resident #6's NSA did not include any instructions for their additional needs. One of the facility nurses stated at no time did they coordinate with the outside agency regarding Resident #6's injuries nor did they make revisions to the resident's NSA.
3	.330.06.a. Additional Resident Records.	The facility did not evaluate residents' behaviors. For example, Resident #2 made comments of suicidal and homicidal ideation. They were also observed to make inappropriate sexual comments and sexual threats towards female caregivers. Resident #1 engaged in behaviors of hitting others and invading the personal space of other residents. The administrator confirmed the behavior evaluations had not been completed.
4	.330.06.b. Additional Resident Records.	The facility did not develop at least one intervention specific for each maladaptive behavior nor review interventions as appropriate to evaluate the effectiveness and continued need for the interventions. For example, Resident #1 did not have interventions in place when they hit residents and staff, and Resident #2 did not have interventions in place when they exhibited homicidal and suicidal ideation. Resident #4 had resident to resident altercations on 11/29/25, 12/7/25, 1/9/26, 2/20/26, 5/16/26 (twice), 5/26/26, and 6/4/26 and no new interventions were put into place to prevent these altercations nor protect residents. The administrator confirmed these residents did not have interventions in place for these maladaptive behaviors and no new interventions were put into place for Resident #4.
5	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 fell 3 times on 2/20/26, and on 2/25/26, 2/26/26, and 2/28/26. One of the facility nurses stated they did not immediately implement corrective action.