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
Bennett Kirk Goodin	Coeur d' Alene	83815	01/29/2025
Survey Team Leader	Survey Type		Response Due
Perry, Bradley	health care complaint investigation		02/28/2025

Item #	Rule (16.03.22)	Description
1	.305.02.b. Current Medication Orders and Treatment Orders.	The facility did not ensure residents received medications as ordered. For example, Resident #3 did not receive their scheduled twice a day Eliquis seven times between 12/15/24 and 12/19/24 and seven times between 1/16/25 and 1/21/25, did not receive their scheduled Zyrtec 10 times between 12/13/24 and 12/29/24, and did not receive their scheduled melatonin five times between 1/15/25 and 1/20/25. Resident #6 did not receive their scheduled atenolol, citalopram, hydrochlorothiazide, hyoscyamine, lamotrigine, lidocaine patch, potassium, risperidone, and senexon on 10/8/24. The facility nurse stated Resident #3's medications were not administered as ordered. ***Previously cited on 8/23/24.***
2	.310.01.f. Medication Distribution System.	The medication technician did not observe all residents take their medications when assisting with medications. For example, Resident #6's medications were placed in a medication cup, handed to Resident #6, and then the medication technician walked away to continue with the medication pass. The same medication technician was observed handing two unsampled residents their medications and then walked away without observing the residents taking their medications. The facility nurse stated medication

		technicians were to observe all residents take their medications at all times.
3	.335.02. Standard Precautions.	The facility did not follow standard infection control procedures. For example, a medication technician was observed not washing or sanitizing their hands in between resident medication passes, caregivers were observed using bare hand contact with ice and serving it to residents, a contaminated ice scoop was observed to be stored directly in the ice bin in the Cedar building freezer and then served to residents, and a kitchen staff was observed touching ready to eat rolls with contaminated gloves in multiple buildings. The facility nurse stated facility staff were still learning proper infection control procedures.
4	.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 and required more than one staff member to manage their behaviors which left only one staff in each building. The administrator stated they were working on hiring more staff to have a care staff assigned to each building and two medication technicians to float between two buildings for day and evening shifts, and one float for the night shift.