# NON-CORE ISSUES

| Facility | License # | Physical Address | Phone Number |
|---|---|---|---|
| Copper Springs | RC-1318 | 3570 E Amity Rd | (208) 888-7030 |
| Administrator | City | Zip Code | Survey Date |
| Michael Crowley | Meridian | 83642 | 11/15/2024 |
| Survey Team Leader | Survey Type | | Response Due |
| Walker, Jenny | Health Care Initial Licensure + complaint investigation | | 12/15/2024 |

| Item # | Rule (16.03.22) | Description |
|---|---|---|
| 1 | .260.07. Toxic Chemicals. | The facility did not secure cleaning chemicals in the laundry room accessible to cognitively impaired residents from 11/12/24 to 11/14/24. For example, in building #3 a bottle of "Hepacide quat" disinfectant was observed in the unlocked laundry room. In building #1, laundry soap and bleach were observed to be in an unlocked laundry room. The facility administrator stated chemicals needed to be secured. |
| 2 | .310.01.c. Medication Distribution. | The facility's medication refrigerator temperatures were not monitored and documented daily. In building #1, the medication refrigerator temperatures were not documented ten days in October 2024. In building #3, the medication refrigerator temperatures were not documented 26 days in September 2024, 30 days in October 2024 and 4 days in November 2024. The facility nurse stated she was not aware they had not been documented. |
| 3 | .310.01.g. Medication Distribution System. | The facility did not ensure all residents' as-needed (PRN) medications were available. For example, Resident #5's Systane eye drops and an unsampled resident's Calmoseptine ointment were not available in the facility's medication cart. The facility nurse stated she was unaware PRNs were not available in the medication cart. |

| | | |
|---|---|---|
| 4 | .320.08. Periodic Review. | Negotiated Service Agreements (NSAs) were not updated to reflect significant changes in Resident #1, #2 and #4's health/physical status. Resident #1's NSA documented they were on a regular diet and they were on a doctor ordered mechanical soft diet. Resident #2's NSA documented they were independent with ambulation and transferring and Resident #2 was observed in a Broda wheelchair. Multiple staff stated Resident #2 was immobile in their Broda wheelchair and required staff assistance to move their wheelchair. Resident #4 fell and fractured their arm on 9/27/24 and their NSA was not updated to reflect their need for shower assistance, for which they were previously independent. Resident #4 stated they had trouble finding staff to provide shower assistance since they fractured their arm. The facility nurse stated the NSAs needed to be updated. |
| 5 | .451.01.c. MENU AND DIET PLANNING. | The facility's menu was not posted in the common areas of memory care buildings #1 and #3, for residents to view. The administrator stated the menus needed to be posted in the two memory care buildings, which ceased when the facility hired their current dietary manager. |
| 6 | .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, the facility routinely scheduled one medication technician and two caregivers at night for three buildings. The facility as-worked schedules between 9/29/24 and 10/2/24 and from 11/7/24 and 11/10/24, documented a medication technician was in building #4 and a caregiver was in building #1 and another caregiver in building #3, with no other staff in the buildings. 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 had to leave one building to pass medication in another building. Also, the facility resident roster for building #3 documented three residents required |

| | | |
|---|---|---|
| | | two-person assistance with transfers. Staff members stated when staff in building #3 needed help to transfer one of these residents in building #3 at night, staff in another building had to leave their building unattended until they finished helping with the resident transfer in building #3. The facility administrator stated he was aware staff had been switching buildings at night. |
| 7 | .625. ORIENTATION TRAINING REQUIREMENTS. | Four of four staff, who were retained through the change of ownership, whose records were reviewed, did not have 16 hours of job related orientation and infection control training. The business office manager stated they did not receive 16 hour job related orientation and infection control with the change of ownership from 6/10/24. |
| 8 | .630. TRAINING REQUIREMENTS FOR FACILITIES ADMITTING RESIDENTS WITH A DIAGNOSIS OF DEMENTIA, MENTAL ILLNESS, DEVELOPMENTAL DISABILITY, OR TRAUMATIC BRAIN INJURY. | Four of four staff, who were retained through the change of ownership, whose records were reviewed, did not have specialized training for residents with dementia, mental illness, traumatic brain injuries, and developmental disabilities. The facility retained residents that had these diagnoses. The business office manager stated they did not receive specialized training with the change of ownership from 6/10/24. |