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
Brandon McKenzie	Meridian	83642	02/05/2026
Survey Team Leader	Survey Type		Response Due
Cerovski, Wendy	Health Care Licensure and Follow-Up		03/07/2026

Item #	Rule (16.03.22)	Description
1	.009.01. Criminal History and Background Check.	Two of five employees, whose personnel records were reviewed, did not have a Department Criminal History and Background Check. The administrator confirmed the Department Criminal History and Background Checks were not completed.
2	.009.06.c. Use of Previous Criminal History and Background Check.	Four of nine employees, whose files were reviewed and required an Idaho State Police background check, did not have the check completed prior to working alone with residents. The administrator confirmed the Idaho State Police background check results were not completed and the employees had been working alone with residents.
3	.161.04. Designated Smoking Areas.	The facility did not have designated smoking areas clearly marked. During observations on 2/3/26 and 2/4/26, the secured courtyards in building #1 and #3 were observed to be the smoking area and two residents in each building were observed smoking. There was no smoking sign posted. The care staff confirmed there were no signs posted. ***Previously cited on 6/5/25***
4	.250.09. Resident Sleeping Rooms.	The water temperatures in the facility were not maintained between 105 to 120 degrees F. For example, on 2/3/26 and 2/4/26, water temperatures in building #3 were as high as 129

		degrees F, in building #1 they ranged between 92 and 113, and in building #4 they ranged between 99 and 117. Both the maintenance technician and administrator stated that they were aware of temperatures out of range.
5	.250.12.j. Resident Sleeping Rooms.	Resident sleeping rooms must have doors that will limit the passage of smoke, and provide the resident(s) with privacy. Eight of building #2's resident rooms did not have door latch or knob mechanisms to prevent the passage of smoke in the event of fire and did not allow for privacy in resident rooms.
6	.260.06. Toxic Chemicals.	The facility was not maintained in a clean, safe, and orderly manner. For example: the shower room flooring in both memory care buildings (#1 and #3) were black, greasy, and had grime along the caulking between the shower floor and tile. One of two shower rooms in building #1 was missing the threshold between the shower and the floor, making the shower inoperable. The drywall near the floor strip was stripped and damaged in building #3's shower room. A cabinet door in building #3's kitchen below the sink was detached and taped together with clear adhesive tape.
7	.310.01.a. Medication Distribution.	On 2/3/26 and 2/4/26, medications in bubble packs were observed unsecured in memory care building #1's office. The office door was left opened and access to the office was obtained by walking through the kitchen entryway. The kitchen entryway door had a sign which stated "Employees Only" and on several occasions, staff either left the kitchen door opened or unlocked as they left the area. The facility nurse stated medications should always be secured.
8	.310.04.e. Psychotropic or Behavior Modifying Medication.	Resident #1 was taking trazadone, the last six-month psychotropic medication review was 7/4/25, and did not include behavioral updates. Resident #2 was taking haloperidol, quetiapine, and sertraline, the last six-month psychotropic medication was 1/27/26, and did not include behavioral updates. Resident #4 was taking mirtazapine, quetiapine fumarate, and fluoxetine, the last six-month

		psychotropic medication was 7/4/25, and did not include behavioral updates. Resident #5 was taking escitalopram, the last six-month psychotropic medication was 1/6/26, and did not include behavioral updates. Resident #7 was taking oxazepam, the last six-month psychotropic medication was 1/6/26, and did not include behavioral updates. The facility nurse confirmed that behavioral updates were not included.
9	.330.04. Behavior Documentation.	The facility did not document the number of insulin units given for Resident #6 and two unsampled residents, who required insulin on a sliding scale. Several medication technicians stated the computer system did not have a place to record the units given and they did not record the units anywhere else. The facility resident care coordinator confirmed the system did not have a place to document units given.
10	.330.13. Personnel Records.	The facility did not maintain staff records with all required documentation. For example, three of nine staff records reviewed did not contain documentation of medication technician certifications. The administrator confirmed the trainings had been completed but were not available at the time of survey.
11	.330.15. Fire and Life Safety Records.	The facility must ensure the facility's records for fire and life safety were maintained. For example, the facility did not provide documentation of the alarm system 5-year sensitivity testing. The facility administrator confirmed the documentation was not available. ***Previously cited on 6/5/25***
12	.335.02. Standard Precautions.	The facility did not perform standard infection control precautions. For example, medication technicians in building #4 did not consistently use hand hygiene between resident medication passes. Staff in buildings #1 and #3 did not wear aprons while performing kitchen tasks, such as preparing and plating food, after they had been observed providing cares to residents. The facility nurse stated staff should perform hand hygiene after medication passes and wear aprons in the

		kitchen.
13	.405.03. Telephone.	The facility failed to store oxygen tanks securely in racks or carts. For example, two tanks were observed to be unsecured, and standing upright behind the door in room 211 in building #4, and one tank was observed unsecured in the medication room in building #3.
14	.410. REQUIREMENTS FOR EMERGENCY ACTIONS AND FIRE DRILLS.	The facility failed to conduct fire drills for buildings #1, #3, or #4, in accordance with the rule. Fire drills were not conducted at least 6 per year on a bi-monthly basis with two being conducted during the night during normal sleeping hours. The facility administrator acknowledged that fire drill records were not completed accurately. ***Previously cited on 6/5/25***
15	.625. ORIENTATION TRAINING REQUIREMENTS.	Seven of fourteen staff, whose records were reviewed, did not have 16 hours of job related orientation training. The administrator confirmed they did not receive 16 hour job related orientation.***Previously cited on 11/15/24.***