



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

March 2, 2015

Steve Silberberger, Administrator
Seven Oaks Community Homes - Tybalt
3940 West 5th Avenue #C
Post Falls, ID 83854

RE: Seven Oaks Community Homes - Tybalt, Provider #13G023

Dear Mr. Silberberger:

This is to advise you of the findings of the Medicaid/Licensure survey of Seven Oaks Community Homes - Tybalt, which was conducted on February 26, 2015.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form which states that no State deficiencies were noted at the time of the survey. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;
2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;
4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;
5. The plan must include the title of the person responsible for implementing the acceptable plan of correction; and

Steve Silberberger, Administrator
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6. Include dates when corrective action(s) will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions, which require construction, competitive bidding or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **March 12, 2015**, and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in the State Informal Dispute Resolution (IDR) Process which can be found on the Internet at:

www.icfmr.dhw.idaho.gov

Scroll down until the Program Information heading on the right side is visible and there are three IDR selections to choose from.

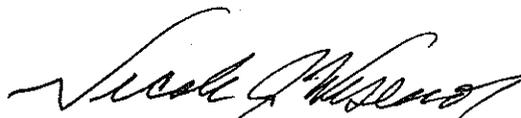
This request must be received by March 12, 2015. If a request for informal dispute resolution is received after March 12, 2015, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626, option 4.

Sincerely,



MICHAEL CASE
Health Facility Surveyor
Non-Long Term Care



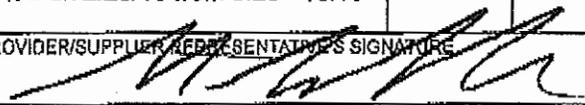
NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/pmt
Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/02/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G023	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/26/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - TYBALT			STREET ADDRESS, CITY, STATE, ZIP CODE 669 NORTH TYBALT POST FALLS, ID 83854		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 000	INITIAL COMMENTS The following deficiency was cited during the recertification survey conducted from 2/23/15 to 2/26/15. The survey was conducted by: Michael Case, LSW, QIDP	W 000			
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure evacuation drills were conducted quarterly for each shift of personnel for 5 of 5 individuals (Individuals #1 - #5) residing at the facility. This resulted in the potential for the facility and staff not being able to determine individuals' responses or identify problem areas. The findings include: 1. The facility utilized an "A - B" shift schedule where shift A worked from 6:00 a.m. - 10:00 p.m. Sunday - Tuesday and every other Wednesday, and shift B worked from 6:00 a.m. - 10:00 p.m. Thursday - Saturday and every other Wednesday. The facility's evacuation drills were reviewed and did not include documentation that an evacuation drill had been completed for the B shift of staff during the fourth quarter (October - December) 2014. During an interview on 2/26/15 from 9:25 - 10:15	W 440	THE HOME WILL HAVE A FIRE DRILL SCHEDULE THAT MEETS THE QUARTERLY REQUIREMENTS FOR EACH SHIFT. THE OFFICE MANAGER WILL REVIEW THE DRILLS MONTHLY TO ENSURE THEY WERE RUN AS SCHEDULED. THE CORRECTIONS WAS IMPLEMENTED ON 3/5/15.		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE *ADMIN* (X6) DATE *3/5/15*

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 440	Continued From page 1 a.m., the Program Director and Administrator both stated two evacuation drills had been completed for the A shift by accident (one on 11/25/14 at 7:00 p.m. and one on 12/14/14 at 7:20 p.m.). The Program Manager stated a drill for the B shift had not been completed for the fourth quarter. The facility failed to ensure evacuation drills were completed each quarter for each shift of staff.	W 440			

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - TYBALT	STREET ADDRESS, CITY, STATE, ZIP CODE 669 NORTH TYBALT POST FALLS, ID 83854
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M 000	<p>16.03.11 Initial Comments</p> <p>Seven Oaks - Tybalt is in compliance with the requirements of Idaho Department of Health and Welfare Rules, Title 03, Chapter 11, "Rules Governing Intermediate Care Facilities for the Intellectually Disabled (ICF/ID)" for the annual licensure survey conducted from 2/23/15 to 2/26/15.</p> <p>The survey was conducted by:</p> <p>Michael Case, LSW, QIDP</p>	M 000	<p style="text-align: center;">RECEIVED MAY 09 2015 FACILITY STANDARDS</p>	3/5/15

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE