



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

IDAHO DEPARTMENT OF
HEALTH & WELFARE

DEBBY RANSOM, R.N., R.H.I.T. - Chief
BUREAU OF FACILITY STANDARDS
3232 Eder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

April 8, 2015

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

RE: Seven Oaks Community Homes - Knapp West, Provider #13G068

Dear Mr. Silberberger:

This is to advise you of the findings of the Medicaid/Licensure Fire Life Safety Survey, which was concluded at Seven Oaks Community Homes - Knapp West, on March 30, 2015.

Enclosed is your copy of a Statement of Deficiencies/Plan of Correction, form CMS-2567, which states that no Medicaid deficiencies were noted at the time of the survey. Also, enclosed is a similar form stating that no State licensure deficiencies were noted at the time of the survey.

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

Sincerely,

A handwritten signature in black ink, appearing to read "MPG", with a long horizontal flourish extending to the right.

MARK P. GRIMES
Supervisor
Facility Fire Safety and Construction Program

MPG/lj

Enclosure

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

Printed: 04/06/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G068	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ENTIRE STRUCTURE B. WING _____	(X3) DATE SURVEY COMPLETED 03/30/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - KNAPP		STREET ADDRESS, CITY, STATE, ZIP CODE 2898 KNAPP CIRCLE 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
K 000	<p>INITIAL COMMENTS</p> <p>The facility is a single story residential type building with Type V (000) construction that was built in December of 2005. It is fully sprinklered with quick response heads and has a complete fire alarm/smoke detection system. Currently it is licensed for 5 ICF/MR beds.</p> <p>The facility was found to be in substantial compliance with applicable fire/life safety requirements during the annual Life Safety Code survey conducted on March 30, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Chapter 32, New Residential Board & Care Occupancies, Impractical Evacuation Capability in accordance with 42 CFR 483.470 (j).</p> <p>The Survey was conducted by:</p> <p>Nathan Elkins Health Facility Surveyor Fire Life Safety & Construction</p>	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G068	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ENTIRE STRUCTURE B. WING _____	(X3) DATE SURVEY COMPLETED 03/30/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - KNAPP WES		STREET ADDRESS, CITY, STATE, ZIP CODE 2898 KNAPP CIRCLE 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) COMPLETE DATE
M 000	<p>16.03.11 Initial Comments</p> <p>The facility is a single story residential type building with Type V (000) construction that was built in December of 2005. It is fully sprinklered with quick response heads and has a complete fire alarm/smoke detection system. Currently it is licensed for 5 ICF/MR beds.</p> <p>The facility was found to be in substantial compliance with applicable life safety requirements during the annual Life Safety Code survey conducted on March 30, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Chapter 32, New Residential Board & Care Occupancies, Impractical Evacuation Capability in accordance with 42 CFR 483.470 (j). and IDAPA 16.03.11 Rules Governing Intermediate Care Facilities for People with Intellectual Disabilities.</p> <p>The Survey was conducted by:</p> <p>Nathan Elkins Health Facility Surveyor Fire Life Safety & Construction</p>	M 000		

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE