



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

July 20, 2015

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

RE: Seven Oaks Community Homes - Elm, Provider #13G025

Dear Mr. Silberberger:

This is to advise you of the findings of the Medicaid/Licensure survey of Seven Oaks Community Homes - Elm, which was conducted on July 15, 2015.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. 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
July 20, 2015
Page 2 of 2

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 **August 3, 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 August 3, 2015. If a request for informal dispute resolution is received after August 3, 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: 08/17/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G025	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/15/2015
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NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - ELM	STREET ADDRESS, CITY, STATE, ZIP CODE 630 NORTH ELM STREET POST FALLS, ID 83864
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(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
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W 000 INITIAL COMMENTS

The following deficiencies were cited during the annual recertification survey conducted from 7/13/15 to 7/15/15.

The surveyors conducting your survey were:

Michael Case, LSW, QIDP, Team Lead
Karen Marshall, MS, RD, LD

Common abbreviations used in this report are:

IPP - Individual Program Plan

W 000

W 369 483.460(k)(2) DRUG ADMINISTRATION

The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.

This STANDARD is not met as evidenced by:
Based on observation, record review and staff interviews, it was determined the facility failed to ensure medications were administered without error for 1 of 3 individuals (Individual #4) observed to take medications. This resulted in an individual's fluoride mouthwash being improperly administered. The findings include:

1. Individual #4's 3/23/15 IPP stated he was a 36 year old male whose diagnoses included moderate mental retardation.

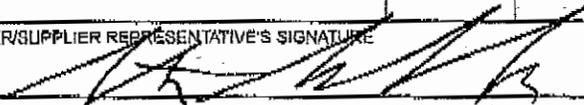
Individual #4's 6/1/15 Physician's Orders sheet contained an order for fluoride mouthwash every day after breakfast and dinner, and another order for Prevident 5000 toothpaste twice daily. The toothpaste order also specified toothpaste and

W 369

see next page

8/15/15

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AUG 21 2015
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ADMINISTRATOR	(X8) DATE 08/14/2015
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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.

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

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NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - ELM			STREET ADDRESS, CITY, STATE, ZIP CODE 630 NORTH ELM STREET 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 369	Continued From page 1 mouthwash must be administered at least one hour apart. His July 2015 Medication Flow Sheet stated he was to receive fluoride mouthwash every day after breakfast and dinner. During a drug pass observation on 7/14/15 from 6:40 @ 6:55 a.m., a direct care staff assisted Individual #4 to rinse his mouth with the fluoride mouthwash. The Home Supervisor was present during the observation. When asked about the administration of the fluoride mouthwash before breakfast, the Home Supervisor stated the toothpaste and the mouthwash were to be given one hour apart. The Home Supervisor reviewed the mouthwash order and said the order did specify after breakfast, not before breakfast. The facility failed to ensure Individual #4's fluoride mouthwash was accurately administered.	W 369	W369 The Manager and the nurse reviewed the error made and adjustments were made to the individuals schedule to alert staff to assist with the medication at the appropriate time. All Medication flows were reviewed and schedules, observations were done to ensure there was no further errors being made with all individuals in the facility. Two additional medication observations will be completed each month, providing further training and support as needed. Completion date 8/15/15 By Whom: QMRP, Home Supervisor and Assistant Home Supervisor		
W 382	483.460(1)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure all drugs and biologicals were maintained under locked conditions, which had the potential to impact 6 of 6 individuals (Individuals #1 - #6) residing at the facility. This resulted in the potential for harm in the event individuals accessed and ingested a drug. The findings include: 1. An observation was conducted at the facility on	W 382		8/16/15	

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NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - ELM		STREET ADDRESS, CITY, STATE, ZIP CODE 630 NORTH ELM STREET 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 382	<p>Continued From page 1</p> <p>7/13/15 from 3:10 - 3:55 p.m. During that time, a bottle of GNC Mega Mens Vitamins (a supplemental drug) was observed to be sitting on a table near the entry way. A bottle of Garcinia Cambogia (an herbal weight loss drug) was observed to be in an unlocked drawer of the table.</p> <p>The Home Supervisor, who was present during the observation, stated she did not know the drugs were there and stated they must have belonged to one of the direct care staff. The Home Supervisor stated the drugs should not be unlocked.</p> <p>The facility failed to ensure all drugs were maintained under locked conditions.</p>	W 382	<p>W382</p> <p>The Vitamin supplements found in the home were identified as a staff's personal item. The item was removed from the house and the staff was counseled.</p> <p>The facility was checked for other drugs/biologicals that should be kept locked, but no others were found. All staff at the facility were told to keep their personal items on them or locked up. A new policy will be implemented that instructs all staff about any drugs/biologicals that they bring into the facility must be kept in its original container, labeled, and identify who it belongs to. The items must be kept in their pocket on them or locked up in the facilities designated locked cabinet. This Policy will go out to all the homes and addressed at the monthly home meeting's. It will also be included in the new hire paperwork.</p> <p>Completion date 8/21/15 By Whom: Administrator, Home Supervisor</p>

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G028	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/15/2015
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NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - ELM	STREET ADDRESS, CITY, STATE, ZIP CODE 630 NORTH ELM STREET POST FALLS, ID 83864
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(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
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M 000 16.03.11 Initial Comments

The following deficiencies were cited during the licensure survey conducted from 7/13/15 to 7/15/15.

The surveyors conducting your survey were:

Michael Case, LSW, QIDP, Team Lead
Karen Marshall, MS, RD, LD

M 000

MM166 16.03.11600 Health Care Services

The requirements of Sections 600 through 699 of these rules are for modifications and additions to the requirements in 42 CFR 483.460 - 483.460(n) (2), Condition of Participation: Health Care Services incorporated in Section 004 of these rules.

This Rule is not met as evidenced by:
Refer to W369 and W382.

MM166

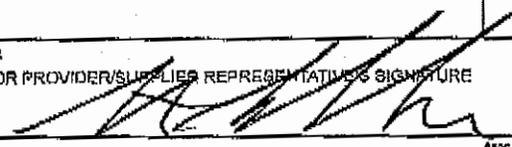
mm 166
REFER TO
W 369 AND W 382

RECEIVED

AUG 21 2015

FACILITY STANDARDS

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



TITLE

ADMINISTRATOR

(X8) DATE

08/14/15