# 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 - Stephanie
3940 West 5th Avenue #C
Post Falls, ID 83854

RE: Seven Oaks Community Homes - Stephanie, Provider #13G054

Dear Mr. Silberberger:

This is to advise you of the findings of the Medicaid/Licensure survey of Seven Oaks Community Homes - Stephanie, 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

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 A Case, LSW

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: | (X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____ | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 13G054 | | 07/15/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SEVEN OAKS COMMUNITY HOMES - STEPHANIE | 615 NORTH STEPHANIE STREET<br>POST FALLS, ID 83854 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDE 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<br><br>The following deficiencies were cited during the annual recertification survey conducted from 7/13/15 to 7/15/15.<br><br>The surveyors conducting your survey were:<br><br>Michael Case, LSW, QIDP, Team Lead<br>Karen Marshall, MS, RD, LD<br><br>Common abbreviations used in this report are:<br><br>CNA - Certified Nursing Assistant<br>CP - Cerebral Palsy<br>G-Tube - Gastrostomy Tube (a tube inserted through the abdomen directly into the stomach)<br>IPP - Individual Program Plan<br>LPN - Licensed Practical Nurse<br>MAR - Medication Administration Record | W 000 | | |
| W 111 | 483.410(c)(1) CLIENT RECORDS<br><br>The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and staff interview, it was determined the facility failed to maintain a record keeping system that contained accurate information for 3 of 3 individuals (Individuals #1 - #3) whose medical records were reviewed. This resulted in potential for medication administration errors. The findings include:<br><br>1. Individual #1's 1/22/15 IPP stated he was a 40 year old male whose diagnoses included severe | W 111 | W111<br><br>The errors identified in the medical records were corrected and initialed by the nurse. Where applicable, the Physician was informed of all errors by fax so his or her records could be corrected. The facility will have a two person document check; The facility nurse and CNA/Medical Assistant will review all Medical records received and check them for accuracy and make the corrections as needed. The Medical doctor affiliated with the paperwork will be notified by fax.<br><br>Completion date 8/15/15<br>By Whom; Facility Nurse, CNA/Medical Assistant | 8/15/15 |

RECEIVED
AUG 21 2015
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 08/14/2015

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

PRINTED: 08/17/2015
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____ | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 13G054 | | 07/15/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SEVEN OAKS COMMUNITY HOMES - STEPHANIE | 615 NORTH STEPHANIE STREET<br>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 111 | Continued From page 1<br>mental retardation, cerebral palsy, quadriplegia, and scoliosis.<br><br>a. Individual #1's Physician's Orders, dated 6/1/15, stated "All meds given Via [sic] G-Tube." However, his History and Physical, dated 4/21/15, included the following information under the "Medication Reconciliation" section:<br><br>- Hyzaar (a antihypertensive drug) 50 mg, Protonix (an antiulcer drug) 1 packet, loratadine (a antihistamine drug) 10 mg, baclofen (a skeletal muscle relaxant drug) 5 mg, Milk of Magnesia (a laxative drug) 30 ml, and ranitidine (a antiulcer drug) 150 mg all stated they were to be taken "by oral route."<br><br>- Baclofen 20 mg and Vitamin D3 (a supplemental drug) 100 mg both stated to take "po" (by mouth).<br><br>- Lisinopril (a antihypertensive drug) 20 mg stated "take 2 tablet by oral route every day via G-tube."<br><br>Individual #1's History and Physical Medication Reconciliation did not provide clear instructions regarding medication administration routes that were consistent with his Physician's Orders.<br><br>b. Individual #1's Physician's Orders, dated 6/1/15, stated he was to receive Lorazepam (an anxiolytic drug) 1 mg 1 hour prior to dental appointments, and could receive an additional 1/2 tablet 30 minutes after the initial dose if needed.<br><br>Individual #1's History and Physical Medication Reconciliation, dated 4/21/15, stated he received Lorazepam 0.5 mg 1 tablet 1 hour prior to dental appointments, and a second tablet 30 minutes | W 111 | | |

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: | (X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____ | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 13G054 | | 07/15/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SEVEN OAKS COMMUNITY HOMES - STEPHANIE | 615 NORTH STEPHANIE STREET<br>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 111 | Continued From page 2<br>after the initial dose if needed.<br><br>Individual #1's History and Physical Medication Reconciliation was not consistent with his Physician's Orders.<br><br>During an interview on 7/15/15 from 1:50 - 2:45 p.m., the LPN stated the Physician's Orders were correct, and the information on the History and Physical was in error and should have been corrected upon review.<br><br>The facility failed to ensure Individual #1's History and Physical included accurate and clear information.<br><br>2. Individual #2's 7/29/14 IPP stated he was a 31 year old male whose diagnoses included profound mental retardation and cerebral palsy.<br><br>Individual #2's Physician's Orders, dated 6/1/15, stated he had a G-tube and that all medications were to be given through his feeding tube. However, his History and Physical, dated 4/21/15, included the following information under the "Medications" section:<br><br>- Diazepam (an anxiolytic drug) 10 mg, ferrous sulfate (an iron supplement) 300 mg, glycopyrrolate (a anticholinergic drug) 1 mg, Miralax (a laxative drug) 17 gram, and prevacid (a antiulcer drug) 30 mg all stated they were to be given "by oral route."<br><br>- Poly-Vita (a supplemental drug) oral drops stated they were to be given "po."<br><br>Individual #2's History and Physical Medication Reconciliation was not consistent with his | W 111 | | |

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: | (X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____ | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 13G054 | | 07/15/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SEVEN OAKS COMMUNITY HOMES - STEPHANIE | 615 NORTH STEPHANIE STREET<br>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 111 | Continued From page 3<br>Physician's Orders.<br><br>During an interview on 7/15/15 from 1:50 - 2:45 p.m., the LPN stated the Physician's Orders were correct, and the information on the History and Physical was in error and should have been corrected upon review.<br><br>The facility failed to ensure Individual #2's History and Physical included accurate information.<br><br>3. Individual #3's 5/29/15 IPP stated he was a 34 year old male whose diagnoses included profound mental retardation, cerebral palsy and a seizure disorder.<br><br>Individual #3's Physician's Orders, dated 6/1/15, documented all medications were given through his G-tube. However, his History and Physical, dated 4/16/15, included the following information under the "Medications" section:<br><br>- Baclofen 10 mg, benztropine (a antiparkinsonian drug) 1 mg, and Zonegran (a anticonvulsant drug) 100 mg all stated to take "po."<br><br>- Lamictal (an anticonvulsant drug) 200 mg, Minocin (an antibiotic drug) 100 mg, Miralax 17 gram, nitrofurantoin monohydrate/marocrystals (an antibiotic drug) 100 mg, Senna-S (a laxative drug) 8.6/50 mg, and sulfamethoxazole/trimethoprim (an antibiotic drug) 800/160 mg all stated to take "by oral route."<br><br>Individual #3's History and Physical Medication Reconciliation was not consistent with his Physician's Orders. | W 111 | | |

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: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 13G054 | | 07/15/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SEVEN OAKS COMMUNITY HOMES - STEPHANIE | 615 NORTH STEPHANIE STREET<br>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 111 | Continued From page 4<br>During an interview on 7/15/15 from 1:50 - 2:45 p.m., the LPN stated the Physician's Orders were correct, and the information on the History and Physical was in error and should have been corrected upon review. | W 111 | | |
| W 326 | The facility failed to ensure individual #3's History and Physical included accurate information.<br>483.460(a)(3)(iii) PHYSICIAN SERVICES<br><br>The facility must provide or obtain annual physical examinations of each client that at a minimum includes special studies when needed.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and staff interviews, it was determined the facility failed to obtain special studies as recommended for 1 of 3 individuals (Individual #1) reviewed, who had risk factors for decreased bone density. This resulted in an individual not receiving bone density screenings as recommended. The findings include:<br><br>1. The National Center for Biotechnology Information (www.ncbi.nlm.nih.gov) published an article by the National Institute of Health summarizing bone density studies for individuals affected by CP and who were non-ambulatory. The article stated "CP is the most prevalent childhood condition associated with osteoporosis." The article stated "Children with CP frequently grow slowly. The impact of this altered growth on skeletal development and bone density is a significant health problem." The article stated slow growth and immobilization (such as being confined to a wheelchair) caused decreased bone mineral density, and stated | W 326 | W326<br><br>The Individual that was identified as High Risk for osteoporosis and had no information regarding Dexa Scan, his Medical M.D. has been informed of the concerns and we are awaiting a response. All of the individuals of the facility were reviewed to see if they had risk factors (such as: immobilization or took specific noted high risk medications) that increased their chance of developing decreased bone density. The facility Nurse then reviewed to ensure all of the individuals with a high risk factor had either a Dexa Scan completed, scheduled appt. to discuss or had an M.D. deem it not necessary and would include the individuals informed guardian consent in this case. The facility nurse will meet monthly to review the individuals with the Facility CNA/Medical Assistant to review for changes of individuals that may become high risk for decreased bone density and follow up as needed for testing.<br><br>Completion 8/15/15<br>By Whom: Facility Nurse, Facility CNA/Medical Assistant | |

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: | (X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____ | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 13G054 | | 07/15/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SEVEN OAKS COMMUNITY HOMES - STEPHANIE | 615 NORTH STEPHANIE STREET<br>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 326 | Continued From page 5<br>"Significantly decreased bone density is virtually universal in non-ambulatory children with moderate to severe CP after the age of 10 years ..." The article stated bone density screening "should be performed for a baseline at the age of 6 years with follow-up every 1 to 2 years depending on individual risk factors."<br><br>Individual #1's 1/22/15 IPP stated he was a 40 year old male whose diagnoses included severe mental retardation, cerebral palsy, quadriplegia, and scoliosis. He was non-ambulatory and required the use of a wheelchair for mobility.<br><br>However, Individual #1's record did not include information related to bone density screening being completed or discussed with his physician.<br><br>During an interview on 7/15/15 from 1:50 - 2:45 p.m., the CNA and LPN both stated they were not aware of a bone density screening being completed for Individual #1.<br><br>The facility failed to ensure Individual #1 received special studies for bone density screening in accordance with his needs. | W 326 | | |
| W 388 | 483.460(m)(1)(i) DRUG LABELING<br><br>Labeling for drugs and biologicals must be based on currently accepted professional principles and practices.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, record review and staff interviews, it was determined the facility failed to ensure all medications were correctly labeled for 3 of 3 individuals (Individuals #1 - #3) residing at | W 388 | | 8/15/15 |

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: | (X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____ | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 13G054 | | 07/15/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SEVEN OAKS COMMUNITY HOMES - STEPHANIE | 615 NORTH STEPHANIE STREET<br>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 388 | Continued From page 6<br>the facility. This resulted in the potential for medication administration errors and subsequent negative impacts to individuals. The findings include:<br><br>1. Individuals #1 - #3's drug labels were observed during medication administration and environmental review. The following was noted:<br><br>a. An observation was conducted at the facility on 7/13/15 from 4:00 - 5:20 p.m. During that time, the following was noted:<br><br>- At 4:25 p.m., a direct care staff prepared Individual #2's medications which were administered through his G-tube. The pharmacy label on the blister pack for glycopyrrolate (an anticholinergic drug) stated it was to be taken by mouth.<br><br>- At 5:10 p.m., a direct care staff prepared Individual #1's medications which were administered through is G-tube. The pharmacy label for two blister packs of baclofen (a skeletal muscle relaxant drug) both stated they were to be taken by mouth.<br><br>b. During an observation on 7/14/15 from 6:30 - 7:35 a.m., Individuals #1 - #3's blister packs were all reviewed. During that time, the following was noted:<br><br>- Individual #1's baclofen 20 mg (5 blister packs) and 10 mg 1/2 tablet (5 blister packs) all stated to give by mouth.<br><br>- Individual #2's glycopyrrolate 1 mg 2 tablets (2 blister packs) and 1 mg 1 tablet (1 blister pack) all stated to give by mouth. | W 388 | W 388<br><br>The facility nurse identified the labeling error reported and immediately<br>took the mislabeled packets to the pharmacy for a correction label.<br>The nurse compared all medications/packets labels for all individuals in the facility to the current P.O. and Med flows for accuracy and correction where needed. The Facility Nurse and CNA/Medical Assistant will provide a double check system to ensure the medication, labels, medication flows are accurate to the current physician orders for all the individuals in the facility.<br><br>Completion 8/15/15<br>By Whom: Facility Nurse, CNA/Medical Assistant | |

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: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 13G054 | | 07/15/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SEVEN OAKS COMMUNITY HOMES - STEPHANIE | 515 NORTH STEPHANIE STREET<br>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 388 | Continued From page 7<br><br>- Individual #3's Lamotrigine (an anticonvulsant drug) 200 mg (2 blister packs) both stated to give by mouth.<br><br>During an interview on 7/15/15 from 1:50 - 2:45 p.m., the LPN stated he checked the medications in from the pharmacy and compared labels on blister packs to the physician's orders and MARs. The LPN stated the pharmacy labels were in error and should have been identified and corrected.<br><br>The facility failed to ensure Individuals #1 - #3's pharmacy labels included accurate administration routes. | W 388 | | |

PRINTED: 08/17/2015
FORM APPROVED

Bureau of Facility Standards

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 13G054 | | 07/15/2015 |

NAME OF PROVIDER OR SUPPLIER: SEVEN OAKS COMMUNITY HOMES - STEPHANIE

STREET ADDRESS, CITY, STATE, ZIP CODE: 615 NORTH STEPHANIE 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) COMPLETE DATE |
|---|---|---|---|---|
| M 000 | 16.03.11 Initial Comments<br><br>The following deficiencies were cited during the licensure survey conducted from 7/13/15 to 7/15/15.<br><br>The surveyors conducting your survey were:<br><br>Michael Case, LSW, QIDP, Team Lead<br>Karen Marshall, MS, RD, LD | M 000 | RECEIVED<br>AUG 21 2015<br>FACILITY STANDARDS | |
| MM080 | 16.03.11100 Governing Body and Management<br><br>The requirements of Sections 100 through 199 of these rules are modifications or additions to the requirements in 42 CFR 483.410 - 483.410(e), Condition of Participation: Governing Body and Management incorporated in Section 004 of these rules.<br><br>This Rule is not met as evidenced by:<br>Refer to W111. | MM080 | MM 080<br>REFER TO W 111 | |
| MM166 | 16.03.11600 Health Care Services<br><br>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.<br><br>This Rule is not met as evidenced by:<br>Refer to W326 and W388. | MM166 | MM 166<br>REFER TO<br>W 326 AND W 388 | |

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: ADMINISTRATOR | (X6) DATE: 08/14/15