



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T. – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dnw.idaho.gov

CERTIFIED MAIL: 7000 0520 0023 1950 8596

January 4, 2016

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

RE: Seven Oaks Community Homes - Cleveland, Provider #13G049

Dear Mr. Silberberger:

Based on the Medicaid/Licensure survey completed at Seven Oaks Community Homes - Cleveland on December 21, 2015, we have determined that Seven Oaks Community Homes - Cleveland is out of compliance with the Medicaid Intermediate Care Facility for Individuals with Intellectual Disabilities(ICF/ID) Condition of Participation of **Client Behavior & Facility Practices (42 CFR 483.450)**. To participate as a provider of services in the Medicaid program, an ICF/ID must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies which caused this Condition to be unmet, substantially limit the capacity of Seven Oaks Community Homes - Cleveland to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). A similar form indicates State Licensure deficiencies.

You have an opportunity to make corrections of those deficiencies, which led to the finding of non-compliance with the Conditions of Participation referenced above by submitting a written Credible Allegation of Compliance/Plan of Correction.

It is important that your Credible Allegation/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;

Steve Silberberger

January 4, 2016

Page 2 of 3

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.

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

Such corrections must be achieved and compliance verified by this office, before February 4, 2016. To allow time for a revisit to verify corrections prior to that date, it is important that the completion dates on your Credible Allegation/Plan of Correction show compliance no later than January 21, 2016.

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **January 17, 2016.**

Failure to correct the deficiencies and achieve compliance will result in our recommending that the Medicaid Agency terminate your approval to participate in the Medicaid Program. If you fail to notify us, we will assume you have not corrected.

Also, pursuant to the provisions of IDAPA 16.03.11.320.04, Seven Oaks Community Homes - Cleveland ICF/ID is being issued a Provisional Intermediate Care Facility for People with Intellectual Disabilities license. The license is enclosed and is effective December 21, 2015, through April 19, 2016. The conditions of the Provisional License are as follows:

1. Post the provisional license.
2. Correct all cited deficiencies and maintain compliance.

Please be aware that failure to comply with the conditions of the provisional license may result in further action being taken against the facility's license pursuant to IDAPA 16.03.11.350.

Be advised, that, consistent with IDAPA 16.05.03.300, you are entitled to request an administrative review regarding the issuance of the provisional license. To be entitled to an administrative review, you must submit a written request by **February 1, 2016.** The request must state the grounds for the facility's contention of the issuance of the provisional license. You should include any documentation or additional evidence you wish to have reviewed as part of the administrative review.

Steve Silberberger
January 4, 2016
Page 3 of 3

Your written request for administrative review should be addressed to:

Debra Ransom, R.N., RHIT
Licensing and Certification Administration, DHW
PO Box 83720
Boise, ID 83720-0009
Phone: (208)334-6626
Fax: (208)364-1888

If you fail to submit a timely request for administrative review, the Department of Health and Welfare's decision to issue the provisional license becomes final. Please note that issues, which are not raised at an administrative review, may not be later raised at higher level hearings (IDAPA 16.05.03.301).

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 January 17, 2016. If a request for informal dispute resolution is received after January 17, 2016 the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

We urge you to begin correction immediately. If you have any questions regarding this letter or the enclosed reports, please contact me at (208) 334-6626, option 4.

Sincerely,



TRISH O'HARA
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

TO/pmt
Enclosures

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

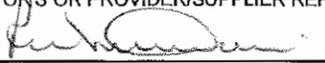
PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND	STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the recertification survey conducted from 12/15/15 to 12/21/15.</p> <p>The surveyors conducting your survey were:</p> <p>Trish O'Hara, RN, Team Lead Michael Case, LSW, QIDP</p> <p>Common abbreviations used in this report are:</p> <p>ABC - Antecedent Behavior Consequence CFA - Comprehensive Functional Assessment CNA - Certified Nurse Aide DCS - Direct Care Staff GERD - Gastroesophageal Reflux Disease H&P - History and Physical IDT - Interdisciplinary Team IPP - Individual Program Plan LPN - Licensed Practical Nurse MAR - Medication Administration Record mg - milligram PICA - A pattern of eating non-food materials QIDP - Qualified Intellectual Disability Professional QMRP - Qualified Mental Retardation Professional TBI - Traumatic Brain Injury</p>	W 000	<p style="text-align: center;">RECEIVED</p> <p style="text-align: center;">JAN 15 2016</p> <p style="text-align: center;">FACILITY STANDARDS</p>	
W 114	<p>483.410(c)(4) CLIENT RECORDS</p> <p>Any individual who makes an entry in a client's record must make it legibly, date it, and sign it.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure that all</p>	W 114		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>President</i>	(X6) DATE <i>1/15/16</i>
--	---------------------------	-----------------------------

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.

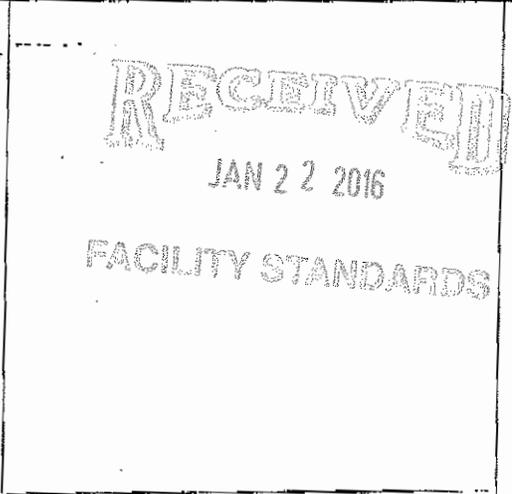
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND			STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 114	<p>Continued From page 1</p> <p>entries in the individuals' records were signed and dated for 1 of 3 individuals (Individual #3) whose records were reviewed. This resulted in a lack of information about who completed entries and when they were completed. The findings include:</p> <p>1. Individual #3 was a 24 year old male with diagnoses including severe mental retardation, TBI, history of seizures and acne.</p> <p>Review of his medical record showed incomplete entries including, but not limited to, the following:</p> <p>a. An order for Doxycycline (an antibiotic drug) 20 mg twice a day, signed by the physician, but not dated.</p> <p>b. A recap order, signed by the physician on 9/4/15, for Doxycycline 20 mg twice weekly. The word "weekly" was crossed out and the word "daily" was inserted. The change was not dated or initialed.</p> <p>c. The same recap order had a handwritten entry for Oxcarbazepine (an anticonvulsant drug) 300 mg. Give 2 1/2 tabs by mouth every a.m. and 3 tabs in p.m. The entry was undated and unsigned.</p> <p>d. An H&P, signed by the physician on 9/30/15, showed a handwritten change to the medication order for Cleocin T 1% Topical Gel. The original order for two times a day was changed to daily. The facility CNA had signed the change, but it was not dated.</p> <p>e. On the same H&P, an order for Provident 5000 Booster 1.1% had been changed, adding "twice a day." The entry was signed by the CNA but not</p>	W 114	<p>W114 Corrective Action: The CNA has been reprimanded for not initialing or signing and for undated changes.</p> <p>Identifying Others Potentially Affected: All individuals living in this home were affected.</p> <p>System Changes: This is an employee disciplinary action. No system changes are indicated.</p> <p>Monitoring: The RN consultant will review documents in the home for unsigned and/or undated entries by medical staff during her monthly home visits. The administrator will review facility records monthly for unsigned and/or undated entries in office record by medical staff.</p> <p>Start Date: January 18, 2016 Completion date: January 21, 2016 Per Administrator on 2.1.16 drug m. case log #109 HFS</p>		

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND			STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 114	Continued From page 2 dated. f. On the same H&P, the directions for Triamcinolone Acetonide 0.5% topical cream had been changed. "Two times a day" was crossed out and "every other day" had been inserted. The entry was signed by the GNA but was not dated. In an interview on 12/17/16 from 10:05 a.m. - 1:05 p.m., the Administrator said the entries should have been signed and dated to ensure the physician was aware of any changes that had been made. All entries to individual #3's record were not signed and dated.	W 114		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on review of investigations and policies, and staff interview, it was determined the facility failed to ensure evidence was present showing an injury of unknown origin was fully investigated for 1 of 1 individuals (Individual #3) who had an injury of unknown origin. This resulted in a lack of clear documentation related to thorough investigation of an unwitnessed injury. The findings include: A policy, dated 7/2007, stated "So long as such injuries are superficial and isolated, it would be expected to normally occur and do not demonstrate any type of a pattern or continuing form of injury, the House Manager will conduct an	W 154		<p>W154 Corrective Action: The House Manager Investigative Report Form, after completion of investigation, will be attached to the Injury Report. The Program Director will receive a copy of Injury Report.</p> <p>Identify Others Potentially Affected: All individuals in the home.</p> <p>System Changes: Please refer to corrective action.</p> <p>Monitoring: When the Program Director receives copy of Injury Form, she will keep a file and follow up within 24 hours to make sure Investigative Report is completed by the house manager.</p> <p>Completion Date: January 21, 2016</p>

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND			STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 154	Continued From page 3 investigation using the House Manager Investigative Report Form. The form, when completed, is to be attached to the Injury Report Form and forwarded to the Administrator's office." Individual #3 was a 24 year old male with diagnoses including severe mental retardation, cortical blindness, and TBI. A one page Injury Report, dated 8/22/15, was reviewed for Individual #3. The report showed staff had discovered, while showering Individual #3, bruising on his right lower hip and the back of his left thigh. The report was signed by medical staff on 8/24/15 and 8/27/15, and the House Manager on 8/27/15. The report stated the injury had occurred "getting in and out of van." However, there was no documentation an investigation had been conducted or how the cause of the injury had been determined. A House Manager Investigative Report Form was not found. During an interview on 12/17/15 from 10:05 a.m. - 1:05 p.m., the Program Director and the Administrator said an investigation, including corrective action, had been done but was not documented.	W 154			
W 159	483.430(a) QIDP Each client's active treatment program must be integrated, coordinated and monitored by a	W 159			

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND			STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 159	<p>Continued From page 4</p> <p>qualified intellectual disability professional. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure the QIDP provided sufficient monitoring and oversight which directly impacted 3 of 3 individuals (Individuals #1 - #3) reviewed, and had the potential to impact all individuals (Individuals #1 - #4) residing at the facility. That failure resulted in a lack of sufficient QIDP monitoring and oversight being provided. The findings include:</p> <p>1. Individual #3's 9/24/15 IPP stated he was a 24 year old male whose diagnoses included severe mental retardation, TBI, cortical blindness, cerebral palsy and a history of seizures. He was admitted to the facility on 7/31/15.</p> <p>Individual #3's record included a Plan Sheet for "Behaviors of Note." The Plan Sheet, undated, stated "The intent of this 'Program' is to provide some information related to documentation of significant or unusual behaviors..." The Plan Sheet stated staff were to record the behavior on the attached ABC style data sheet, and stated "Be sure to include the date, your initials, the circumstances around the behavior, a clear description of the behavior itself, and a description of the consequence to the behavior."</p> <p>The data sheet was reviewed and did not include sufficient information to evaluate the behavior and the efficacy of the interventions. Examples included, but were not limited to, the following:</p> <p>- 9/12/15: In the Time column staff documented "5:30 - 6:15." Under "Antecedent Events" staff documented "Dinner time." Under "Behavior"</p>	W 159	<p>W159</p> <p>Corrective Action: All mal adaptive behavior programs, including plan sheets and data collection protocols, have been reviewed by the QIDP and the Program Director and changes are complete.</p> <p>Identifying Others Potentially Affected: All individuals in the home.</p> <p>System Changes: A companywide Quality Assurance program has been implemented. See attached policy</p> <p>Monitoring: In addition to Quality Assurance Program, the house manager will review all behavior notes, logs and data sheets relating to behavior 3 times a week and QIDP, weekly.</p> <p>Completion Date: January 21, 2016</p> <p>Please refer to W210, W214, W239W, 259, W312</p>	

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND	STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 159	<p>Continued From page 5</p> <p>staff documented "[Individual #3] did everything from yelling, hitting, taking clothes off, Pinching, scratching [and] all for 1:1 time while eating." Under "Consequent Events" staff documented "Ignored behavior/Redirected to Room for Break [sic]."</p> <p>It was not clear what the sequence of events were, who the behaviors were directed at (other individuals, staff, or himself), when staff provided which interventions, or the effectiveness of the interventions provided.</p> <p>- 11/21/15 at 12:35 (a.m./p.m. not indicated): Under "Antecedent Events" staff documented "threw [sic] making lunch [and] threw lunch." Under "Behavior" staff documented "yelling, trying to take off shirt [and] pants. Hitting staff and trying to hit staff and trying to hit Roomates [sic]." The "Consequent Events" column was blank.</p> <p>It was not clear what the sequence of events were, what prompts had been provided, what interventions, if any, had been attempted, etc.</p> <p>- 12/3/15 at 8:15 (a.m./p.m. not indicated): Under "Antecedent Events" staff documented "Brushing Teeth." Under "Behavior" staff documented "Became agitated w/Task." Under "Consequent Events" staff documented "Redirected."</p> <p>It was not clear what "agitated w/Task" meant (what actual behavior was exhibited such as yelling, pushing staff way, physical aggression, etc.), what, if any, cues were provided before or during the incident, how staff redirected (physically, verbally, back to task, to another task, etc.), or if the intervention was effective.</p>	W 159		
-------	--	-------	--	--

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND		STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 159	<p>Continued From page 6</p> <p>During an interview on 12/18/15 from 10:05 a.m. - 1:05 p.m., the QIDP and Program Director both stated the information collected for the "Behaviors of Note" Plan Sheet were to evaluate new or different behaviors. The QIDP and Program Director both stated they had not reviewed the data, and stated the data present did not provide sufficient information to give a clear understanding of the behavior witnessed. The QIDP stated the information should have been reviewed and evaluated.</p> <p>The facility failed to ensure the QIDP ensured <u>data gathered</u> to identify new and emerging behaviors was reviewed and addressed.</p> <p>2. Refer to W210 as it relates to the facility's failure to ensure the QIDP ensured an initial CFA was performed on a newly admitted individual within 30 days.</p> <p>3. Refer to W214 as it relates to the facility's failure to ensure the QIDP ensured individuals' assessments contained comprehensive information.</p> <p>4. Refer to W224 as it relates to the facility's failure to ensure the QIDP ensured individuals were assessed for their ability to learn independent skills.</p> <p>5. Refer to W237 as it relates to the facility's failure to ensure the QIDP ensured training programs specified the form and frequency of data necessary to be able to assess individuals' progress toward meeting objectives.</p> <p>6. Refer to W239 as it relates to the facility's failure to ensure the QIDP ensured replacement</p>	W 159		

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND			STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 159	Continued From page 7 behavior training was appropriate to address individuals' maladaptive behaviors. 7. Refer to W252 as it relates to the facility's failure to ensure the QIDP ensured sufficient data was collected to determine the efficacy of individuals' intervention strategies. 8. Refer to W259 as it relates to the facility's failure to ensure the QIDP ensured CFAs were updated annually and as needed for individuals. 9. Refer to W274 as it relates to the facility's failure to ensure the QIDP ensured the behavior management policy was sufficiently implemented to address an individual's maladaptive behavior. 10. Refer to W288 as it relates to the facility's failure to ensure the QIDP ensured techniques to manage an individual's inappropriate behavior were not used as a substitute for an active treatment program. 11. Refer to W312 as it relates to the facility's failure to ensure the QIDP ensured drugs to modify an individual's maladaptive behavior were sufficiently incorporated into a plan.	W 159			
W 210	483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. This STANDARD is not met as evidenced by:	W 210			

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND			STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND STREET POST FALLS, ID 83864		
(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 210	<p>Continued From page 8</p> <p>Based on record review and staff interview, it was determined the facility failed to ensure assessments were conducted within 30 days of admission for 1 of 1 individual (Individual #3) whose records were reviewed and who was admitted to the facility within the last year. This resulted in a lack of information being available on which to base program intervention decisions. The findings include:</p> <p>1. Individual #3's 9/24/15 IPP stated he was a 24 year old male whose diagnoses included severe mental retardation, TBI, cortical blindness, cerebral palsy and a history of seizures. He was admitted to the facility on 7/31/15 from a sister facility within the same company.</p> <p>a. The facility utilized a CFA tool that addressed seven categories of development including Personal Care, Sensorimotor, Independent Living, Cognitive Skills, Speech and Language, Affective Development and Social Skills. The tool was designed to gather baseline information on new admissions, and was then to be reused yearly allowing the facility to compare ability from year to year and identify needs.</p> <p>However, Individual #3's CFA tool had been completed in October 2014 while at the sister facility, and was not reviewed or revised until November 2015, 4 months after Individual #3 was admitted to the facility.</p> <p>During an interview on 12/18/15 from 10:05 a.m. - 1:05 p.m., the Program Director stated the CFA was "looked at" and felt to be ok, but was not revised. The Program Director stated the CFA should have been completed as individual #3 was a new admission.</p>	W 210	<p>W210</p> <p>Corrective Action: Clarified policy regarding new admissions to include directions that transfer between facilities is treated same as a new admission. Attached is admission form.</p> <p>Identifying Others Potentially Affected: Admissions only.</p> <p>System Changes: Please refer to Corrective Actions</p> <p>Monitoring: The Program Director and Administrator are responsible to process all admissions.</p> <p>Completion Date: January 21, 2016</p>		

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND		STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 210	<p>Continued From page 9</p> <p>The facility failed to ensure comprehensive assessments were conducted within 30 days of admission.</p> <p>b. Individual #3's Occupational Therapy Assessment, dated 10/25/07, recommended the use of deep pressure through the larger joints, a trial of vibration, massage and blanket wrapping in order to help him calm. Additionally, the assessment included recommendations related to Individual #3's resistance to light touch.</p> <p>Attached to the assessment was a QMRP Consultant Report Review form, dated 11/14/07. The form stated "Desensitization program to touch is being addressed through body brushing program added to [Individual #3's] plan this past month and he is provided with a variety of hand held massagers to assist him to calm when agitated. The team discussed the use of deep pressure but felt that this was not appropriate at this time."</p> <p>During an interview on 12/18/15 from 10:05 a.m. - 1:05 p.m., the Program Director stated the Occupational Therapy assessment was the most current. The Program Director stated the assessment had not been reviewed when Individual #3 was admitted to the facility, but it should have been.</p> <p>The facility failed to ensure Individual #3's occupational therapy assessment contained updated information within 30 days of his admission to the facility.</p>	W 210		
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN	W 214		

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND			STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 214	<p>Continued From page 10</p> <p>The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure assessments contained comprehensive behavioral information for 2 of 3 individuals (Individuals #2 and #3) whose assessments were reviewed. This resulted in a lack of information on which to base program intervention decisions. The findings include:</p> <p>During an interview on 12/18/15 from 10:05 a.m. - 1:05 p.m., the Program Director stated the facility did not utilize a specific behavior assessment document, and the only assessment document utilized by the facility was the CFA. The Program Director stated behavior assessment data would be found in reviewing the CFA, narrative sections of the IPP, Section 4 (Restrictive Procedures) of the IPP, and the Behavior Plan Sheets for the individuals.</p> <p>A review of individuals' records documented information related to maladaptive behaviors did not provide sufficient assessment information, as follows:</p> <p>1. Individual #3's 9/24/15 IPP stated he was a 24 year old male whose diagnoses included severe mental retardation, TBI, cortical blindness, cerebral palsy and a history of seizures. He was admitted to the facility on 7/31/15.</p> <p>a. Individual #3's IPP stated he engaged in aggression (defined as hitting, slapping, pinching,</p>	W 214	<p>W214 Corrective Action: Our current CFA is outdated and weak in the area of assessing maladaptive behavior. The CFA will be revised be more specific, directive and encompassing.</p> <p>Identify Others Potentially Affected: All individuals in this home</p> <p>System Changes: Please refer to Corrective Action.</p> <p>Monitoring: All Plan Sheets and Data Sheets will be reviewed by the QIDP to ensure that areas identified from CFA are addressed and the CFA is current. Consulting QIDP from Boise Group Homes will check all plan sheets/data sheets for the next 3 months and report to Seven Oaks president as to progress. Further review may be necessary.</p> <p>Completion Date: January 21, 2016</p>		

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND		STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 214	<p>Continued From page 11</p> <p>scratching, and biting others). Section 4 of the IPP stated he had experienced constipation in the past, which was believed to have increased his aggression, but provided no additional information related to potential causes or functions of the behavior.</p> <p>Individual #3's CFA, dated 11/15, included a statement "Is respectful of others (is not aggressive towards others, does not cause injury to others)." The statement was scored "0," meaning "Is dependent on full physical assistance to perform step in skill..." No additional information was present in the CFA regarding Individual #3's aggression.</p> <p>Individual #3's record included 2 Plan Sheets related to behaviors defined as aggression. His Plan Sheet for Decrease Slapping, revised 1/2015, stated Individual #3 "often slaps others to get out of things, to get attention, and sometimes just out of habit or routine." His Plan Sheet for Decrease Scratching and Pinching, undated, stated Individual #3 would scratch or pinch others when demands were placed on him, when asked to do something he did not want to do, or when he wanted to get out of things.</p> <p>Both plans included directions to staff to body position and provide increased assistance to complete the task if Individual #3 was attempting to get out of an activity, and to not respond if the behavior was for another purpose.</p> <p>Individual #3's CFA, the IPP and Plan Sheets did not include assessment information indicating how to determine if Individual #3 was engaging in the behavior for task avoidance as opposed to attention seeking behavior, or due to habit or</p>	W 214		

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND		STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 214	<p>Continued From page 12 routine.</p> <p>b. Individual #3's IPP stated he engaged in agitation (defined as yelling or swearing), but provided no additional information related to potential causes or functions of the behavior.</p> <p>Individual #3's CFA, dated 11/2015, included a statement "Is respectful of others activities (does not interfere or interrupt...through yelling, screaming...)." The statement was scored "0." No additional information was present in the CFA regarding his agitation.</p> <p>Individual #3's Plan Sheet for Decrease Agitation, dated 2/2015, stated he would yell and/or swear when demands were placed on him, around meal times, to get out of things he didn't want to do, to get attention, and out of habit or routine. The Plan Sheet stated staff were to continue the activity and increase assistance if he was trying to get out of an activity, and were to leave the situation or not respond if he was agitated to get attention or out of habit or routine. There were no instructions related to the behavior during meals.</p> <p>Individual #3's CFA, the IPP and Plan Sheet did not include assessment information indicating how to determine if Individual #3 was engaging in the behavior for task avoidance as opposed to attention seeking behavior, or due to habit or routine. Additionally, no assessment information was present as to why Individual #3 engaged in the behavior around meal times.</p> <p>c. Individual #3's IPP stated he engaged in mouthing items (defined as chewing on clothing or paper products). However, the IPP and CFA did not include information related to the function</p>	W 214		

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND			STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 214	<p>Continued From page 13 of mouthing items.</p> <p>Individual #3's Plan Sheet for Reduce Mouthing Items, undated, did not include information related to the function or cause of the behavior.</p> <p>d. An observation was conducted on 12/14/15 from 3:25 - 4:30 p.m. At 3:25 p.m., Individual #3 struck the sides of his head with cupped hands no fewer than 2 times in rapid succession. The head hits created a noise but not leaving visible marks or injury. Individual #3 repeated the pattern of striking his head 2-3 times at 5-10 minute intervals. During the 65 minute observation, Individual #3 was observed to strike his head no less than 18 times.</p> <p>A second observation was conducted on 12/14/15 from 5:15 - 6:15 p.m. During that time, the following was observed:</p> <ul style="list-style-type: none"> - On 12/14/15 at 5:20 p.m., Individual #3 was observed to pull all the pillows, blankets and sheets from his bed, take them to the recliner in his room, and tuck them around his body creating a swaddling effect. Individual #3 then rocked in the recliner listening to music. At the same time, Individual #3 placed both hands in front of his face with his fingers splayed while looking toward the ceiling light. Individual #3 then shifted the position of his fingers from side to side in what appeared to be an effort to filter the light coming through his fingers. - At 5:25 p.m., while sitting in the recliner in his room, Individual #3 placed his hands in front of his face and clapped 3 times. He repeated the clapping behavior, clapping 2-3 times in front of his face, at intervals ranging from 1-15 minutes 	W 214			

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND			STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 214	<p>Continued From page 14 throughout the observation.</p> <p>Additionally, after clapping, Individual #3 repeated the behavior of filtering light through his fingers using light coming from light fixtures or windows in various locations throughout the facility.</p> <p>Additional observations were conducted at the facility on 12/14/15 from 7:00 - 7:40 p.m., and on 12/15/15 from 7:00 - 8:10 a.m. During those times, Individual #3 observed to engage in the clapping, light filtering and swaddling behaviors noted above intermittently throughout the observations.</p> <p>Additionally, Individual #3's "Behaviors of Note" data, from 8/1/15 - 12/16/15, was reviewed and documented no fewer than 7 incidents of taking his clothing off during maladaptive behaviors. However, assessment information related to the observed and documented behaviors could not be found.</p> <p>During an interview on 12/18/15 from 10:05 a.m. - 1:05 p.m., the Program Director and QIDP both stated new and emerging behaviors, such as the stripping, should be assessed. The Program Director and QIDP both stated many of Individual #3's behaviors appeared to be related to sensory issues.</p> <p>However, Individual #3's Occupational Therapy Assessment, dated 10/25/07, recommended the use of deep pressure through the larger joints, a trial of vibration, massage and blanket wrapping in order to help him calm. Additionally, the assessment included recommendations related to Individual #3's resistance to light touch.</p>	W 214			

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND			STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 214	<p>Continued From page 15</p> <p>Attached to the assessment was a QMRP Consultant Report Review form, dated 11/14/07. The form stated "Desensitization program to touch is being addressed through body brushing program added to [Individual #3's] plan this past month and he is provided with a variety of hand held massagers to assist him to calm when agitated. The team discussed the use of deep pressure but felt that this was not appropriate at this time."</p> <p>Individual #3's IPP included an objective for Body Brushing. However, no other information related to Individual #3's sensory needs or the impact those needs may have on his maladaptive behavior and ability to calm were present in his IPP, CFA, or Plan Sheets.</p> <p>During an interview on 12/18/15 from 10:05 a.m. - 1:05 p.m., the Program Director stated a review of the Occupational Therapy assessment would have identified a need to update the assessment based on Individual #3's sensory needs. The Program Director stated Individual #3's sensory needs had not been assessed, and their potential impact on his maladaptive behaviors had not been identified as an issue. The Program Director stated Individual #3's maladaptive behaviors needed to be reassessed.</p> <p>The facility failed to ensure Individual #3's record included comprehensive behavioral assessment information.</p> <p>3. Individual #2 was a 30 year old male with diagnoses including profound mental retardation, PICA and autism. His 1/20/15 IPP stated he engaged in maladaptive behaviors which included "Loud Vocalizations and "Excited Behavior."</p>	W 214			

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND		STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 214	<p>Continued From page 16</p> <p>Individual #2's undated Plan Sheet for "Excited Behavior" defined "Excited Behavior" as running, hand flapping and making "loud vocalization."</p> <p>However, His IPP included a separate Plan Sheet for "Loud Vocalizations," revised 1/07. There was no definition present as to what a loud vocalization sounded like.</p> <p>Both the "Excited Behavior" and "Loud Vocalization" Plan Sheets stated "Be aware of antecedents and attempt to anticipate the occurrence of loud vocalizations, intervening prior to his having the opportunity to engage in this behavior."</p> <p>Additional assessment information regarding how to distinguish between "Excited Behavior" and "Loud Vocalizations" was not present in Individual #2's CFA, IPP or Plan Sheets.</p> <p>Further, section 4 of Individual #2's IPP stated he had not met criteria relative to his Loud Vocalizations during 2014, but provided no additional information related to potential causes or functions of the behavior.</p> <p>Individual #2's CFA, dated 1/20/15, included a statement "Is respectful of others activities (does not interfere or interrupt, pester, or disrupt through yelling, screaming, tantrumming, [sic] etc." The statement was scored "2." No additional information was present in the CFA regarding the potential causes or functions of Individual #2's loud vocalizations.</p> <p>In an interview on 12/17/15 from 10:05 a.m. - 1:05 p.m., the Program Director said the Plan</p>	W 214		

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND			STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 214	Continued From page 17 Sheets did not clearly state the functional difference between "Excited Behavior" and "Loud Vocalization" for Individual #2.	W 214		
W 224	The facility failed to ensure Individual #2's record included comprehensive behavioral assessment information. 483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include adaptive behaviors or independent living skills necessary for the client to be able to function in the community. This STANDARD is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure CFAs identified current, accurate needs for 3 of 3 individuals (Individuals #1 - #3) whose CFAs were reviewed. This resulted in a lack of information on which to base program objectives. The findings include: 1. Individual #1 - #3's records were reviewed and each contained a restrictive consent to lock toxic chemicals. Individual #1's consent was dated 5/2/15, Individual #2's consent was dated 4/28/15, and Individual #3's consent was dated 5/19/15. All of the consents stated "Individuals will be taught the appropriate use of the toxic chemicals based on an assessment of their skill level." However, none of the records included assessment information to determine their ability to learn to use toxic chemicals safely, or training	W 224 W224 Corrective Action: Refer to 214 as it relates to revision for CFA. Identify Others Potentially Affected: All individuals in the home. System Change: Please refer to Corrective Action Monitoring: None required. Completion Date: January 21, 2016 Please refer to W159		

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND			STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 224	Continued From page 18 programs to teach them to do so.	W 224			
W 237	In an interview on 12/18/15 from 10:05 a.m. - 1:05 p.m., the Program Director confirmed the missing assessments and said Individuals #1 - #3's abilities to learn to use toxic chemicals safely should have been assessed. The facility failed to ensure Individuals #1 - #3's record included assessments related to the ability to safely use toxic chemicals. 483.440(c)(5)(iv) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the individual program plan must specify the type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the training programs specified the type of data necessary to be able to assess progress toward objectives for 2 of 3 individuals (Individuals #2 and #3) whose Behavior Plan Sheets were reviewed. That failure had the potential to prevent the facility from making objective decisions regarding individuals' success or lack of success. The findings include: 1. Individual #3's 9/24/15 IPP stated he was a 24 year old male whose diagnoses included severe mental retardation, TBI, cortical blindness, cerebral palsy and a history of seizures. He was admitted to the facility on 7/31/15.	W 237	W237 Please refer to W159 Please refer to W214		

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND		STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 237	<p>Continued From page 19</p> <p>Individual #3's IPP stated his maladaptive behaviors included aggression (defined as hitting,slapping, pinching, scratching, and biting others), agitation (defined as yelling or swearing), and mouthing items (defined as chewing on clothing or paper products).</p> <p>Individual #3's behavior data was reviewed. The data was not sufficient to adequately assess the efficacy of the intervention strategies, as follows:</p> <p>a. Individual #3's Plan Sheet for Decrease Slapping, revised 1/2015, stated staff were to "Record a tally mark for each occurrence of [Individual #3] slapping others on the Behavior Log II data sheet." The Plan Sheet stated each episode could include slapping others or items such as tables, walls, or other objects.</p> <p>The Plan Sheet stated Individual #3 "often slaps others to get out of things, to get attention, and sometimes just out of habit or routine." The Plan Sheet stated staff were to body position and provide increased assistance to complete the task if he was attempting to get out of something, and were to leave the situation or not respond if he was slapping to get attention or out of habit or routine.</p> <p>Individual #3's Behavior Log II for "Reduce Slapping" consisted of a grid with a column for each day of the week and a row for each hour time frame from 6:00 a.m. - 9:00 p.m.</p> <p>However, the tally data did not provide information related to the maladaptive behavior that would show what was happening prior to the incident, the actual behaviors that were observed (slapping others or slapping an object), what</p>	W 237	<p>W237</p> <p>Please refer to W159</p> <p>Please refer to W214</p>	

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND		STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 237	<p>Continued From page 20</p> <p>interventions staff provided (body positioning or ignoring), or how Individual #3 responded to the interventions.</p> <p>b. Individual #3's Plan Sheet for Decrease Agitation, dated 2/2015, stated staff were to record tally mark data for each occurrence on the Behavior Log II data sheet.</p> <p>The Plan Sheet stated Individual #3 would yell and/or swear when demands were placed on him, around meal times, to get out of things he didn't want to do, to get attention, and out of habit or routine. The Plan Sheet stated staff were to continue the activity and increase assistance if he was trying to get out of an activity, and were to leave the situation or not respond if he was agitated to get attention or out of habit or routine.</p> <p>Individual #3's Behavior Log II for "Decrease Agitation" consisted of a grid with a column for each day of the week and a row for each hour time frame from 6:00 a.m. - 9:00 p.m.</p> <p>However, the tally data did not provide information related to the maladaptive behavior that would show what was happening prior to the incident, the actual behaviors that were observed (yelling or swearing), the function of the behavior (response to demands, meals, to avoid a task, to get attention, or out of habit or routine), what interventions staff provided (body positioning or ignoring), or how Individual #3 responded to the interventions.</p> <p>c. Individual #3's Plan Sheet for Reduce Mouthing Items, undated, stated staff were to "record a tally for any episodes of the hourly data sheet provided."</p>	W 237		

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND		STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 237	<p>Continued From page 21</p> <p>The Plan Sheet stated Individual #3 had a tendency to "chew on his shirt or mouth and bite other items such as work tasks that are in his environment."</p> <p>Individual #3's Behavior Log II for "Reduce Mouthing Items" consisted of a grid with a column for each day of the week and a row for each hour time frame from 6:00 a.m. - 9:00 p.m.</p> <p>However, the tally data did not provide information related to the maladaptive behavior that would show what was happening prior to the incident, what item was mouthed, or how Individual #3 responded to the redirection.</p> <p>During an interview on 12/18/15 from 10:05 a.m. - 1:05 p.m., The Program Director and QIDP both stated the data was not sufficient to assess Individual #3's programs.</p> <p>The facility failed to ensure the type of data collected for Individual #3's maladaptive behaviors provided sufficient information to adequately assess the efficacy of the intervention strategies.</p> <p>2. Individual #2 was a 30 year old male with diagnoses including profound mental retardation, PICA and Autism.</p> <p>Individual #2's IPP stated his maladaptive behaviors included loud vocalizations (undefined) and excited behavior (defined as running, hand flapping and loud vocalizations).</p> <p>Individual #2's behavior data was reviewed. The data was not sufficient to adequately assess the</p>	W 237		

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND			STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 237	<p>Continued From page 22 efficacy of the intervention strategies, as follows:</p> <p>a. Individual #2's Plan Sheet for Loud Vocalizations, revised 1/07, both at home and at the day program site, stated staff were to "Record any episode which exceeds 5 seconds by placing a tally mark in the column corresponding with the correct date and time."</p> <p>However, the tally data reviewed did not provide information related to the maladaptive behavior that would show what was happening prior to the incident, the actual behaviors that were observed, what interventions staff provided, or how Individual #2 responded to the interventions.</p> <p>b. Individual #2's undated Plan Sheet for Excited Behavior at the day program site did not include any instructions to staff related to data collection for the behavior.</p> <p>During an interview on 12/18/15 from 10:05 a.m. - 1:05 p.m., the Program Director and QIDP both stated staff were expected to document maladaptive behaviors using the Antecedent/ Behavior/Consequent Events form. The Program Director and QIDP both stated the data was not sufficient to assess Individual #2's programs.</p> <p>The facility failed to ensure the type of data collected for Individuals #2's maladaptive behaviors provided sufficient information to adequately assess the efficacy of the intervention strategies.</p>	W 237			
W 239	483.440(c)(5)(vi) INDIVIDUAL PROGRAM PLAN	W 239			

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

PRINTED: 12/31/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND			STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 239	<p>Continued From page 23</p> <p>Each written training program designed to implement the objectives in the individual program plan must specify provision for the appropriate expression of behavior and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure replacement behavior training was appropriate to address individuals' maladaptive behaviors for 1 of 3 individuals (Individual #3) whose behavior plans were reviewed. This resulted in an individual not receiving functional training to replace his maladaptive behaviors. The findings include:</p> <p>1. Individual #3's 9/24/15 IPP stated he was a 24 year old male whose diagnoses included severe mental retardation, TBI, cortical blindness, cerebral palsy and a history of seizures. He was admitted to the facility on 7/31/15.</p> <p>a. Individual #3's Decrease Slapping Plan Sheet, revised 1/2015, defined the behavior as slapping others or objects such as tables. The Plan Sheet stated Individual #3 "often slaps others to get out of things, to get attention, and sometimes just out of habit or routine."</p> <p>However, Individual #3's record did not include training for functionally related replacement behaviors such as seeking attention appropriately, or appropriate ways to get out of an activity.</p>	W 239	<p>W239</p> <p>Corrective Action: The QIDP and Program Director have reviewed data collection and made changes to include staff instructions, sufficient information to determine effectiveness of interventions.</p> <p>Identify Others Potentially Affected: All individual in the home.</p> <p>System Change: Quality Assurance Program has been implemented. See attach policy.</p> <p>Monitoring: See W214</p> <p>Completion Date: January 21, 2016</p>	

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND		STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 239	Continued From page 24 b. Individual #3's Decrease Scratching and Pinching Plan Sheet, undated, defined the behavior as scratching or pinching others. The Plan Sheet stated Individual #3 would scratch and pinch "when he is very agitated over someone attempting to get him to do something he does not want to do..." or "...to get out of things." However, Individual #3's record did not include training for functionally related replacement behaviors, such as refusing a task appropriately, or appropriate ways to get out of an activity. During an interview on 12/18/15 from 10:05 a.m. - 1:05 p.m., the Program Director stated replacement behavior training needed to be developed.	W 239		
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure sufficient data was collected to determine the efficacy of intervention strategies for 3 of 3 individuals (Individuals #1 - #3) whose behavioral data was reviewed. That failure had the potential to impede the ability of the treatment team in	W 252		

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND			STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 252	<p>Continued From page 25</p> <p>evaluating the effectiveness of programmatic techniques. The findings include:</p> <p>1. Individual #3's 9/24/15 IPP stated he was a 24 year old male whose diagnoses included severe mental retardation, TBI, cortical blindness, cerebral palsy and a history of seizures. He was admitted to the facility on 7/31/15.</p> <p>Individual #3's behavior plans and data, from 8/1/15 - 12/16/15, were reviewed. The data did not provide sufficient information, as follows:</p> <p>a. Individual #3's Plan Sheet for Decrease Scratching and Pinching, undated, stated "Document each episode on behavior log 1. Be sure to be specific whether scratching or pinching."</p> <p>The Plan Sheet stated Individual #3 would scratch or pinch others when demands were placed on him, when asked to do something he did not want to do, or when he wanted to get out of things. The Plan Sheet stated staff were to body position and provide increased assistance to complete the task if he was attempting to get out of an activity, or not respond if it was because he was asked to do something he did not want to do or he wanted to get out of something.</p> <p>Individual #3's Behavior Log I for Decrease Scratching and Pinching consisted of a form with columns for date, time and staff initials. There were three additional columns labeled Antecedent Event (A), Behavior (B), and Consequent Events (C). The Behavior Logs were reviewed from 8/1/15 - 12/17/15. The data did not include sufficient information to evaluate the efficacy of the interventions. Examples included, but were</p>	W 252	<p>W252</p> <p>Please refer to W159</p> <p>Please refer to W214</p> <p>Please refer to W239</p>		

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND		STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 252	<p>Continued From page 26 not limited to, the following:</p> <ul style="list-style-type: none"> - 9/3/15 at 5:30 p.m.: A - staff documented "Dinner." B - "Pinch." C - "Redirected to eat." - 10/30/15: Under time, staff documented "6-9 am." A - "All morning." B - "Pinched/scratch/biting/hitting [sic]." C - "interrupted redirect [sic]." - 12/16/16: Under time, staff documented "8-9." A - "Breakfst [sic]." B - "Scratching staff." C - "Redirected." <p>The data did not provide a clear description of the events related to the behavior (what happened directly before, the number of pinches/scratches, what redirection was used, Individual #3's response to the redirection, etc.). Additionally, it was not clear if the behavior was continuous for those incidents where a time block (e.g. 6-9 or 8-9) was listed.</p> <p>The data was not sufficient to indicate staff had implemented the Behavior Plan Sheet as written (body position and provide increased assistance to complete the task or not respond).</p> <p>During an interview on 12/18/15, the QIDP and Program Director both stated the data was not sufficient to demonstrate if or how Individual #3's behavior plan was followed, or if the interventions were effective.</p> <p>b. Individual #3's Decrease Agitation Plan Sheet, dated 2/2015, and Decrease Slapping Plan Sheet, revised 1/2015, both stated staff were to document tally marks for each occurrence of the behavior on a Behavior Log II data sheet.</p>	W 252		

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND			STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 252	<p>Continued From page 27</p> <p>Individual #3's Behavior Log II data sheets for both Decrease Agitation and Decrease Slapping, from 8/1/15 - 12/16/15, were reviewed. The data sheets consisted of a grid with a column for each day of the week and a row for each hour time frame from 6:00 a.m. - 9:00 p.m., creating a cell for each hour block. The majority of the cells were blank. Some cells contained 0's, and some cells had tally marks and/or numbers.</p> <p>For example, the 10/25/15 column for Decrease Agitation was blank. However, the 10/31/15 column included 0's in all cells with the exception of the 1:00 - 2:00 p.m. cell, which contained a single tally mark. It was not clear if the behavior was not evident on 10/25/15, or if staff failed to complete documentation for the day.</p> <p>Additionally, the cells for 7:00 - 8:00 a.m. and 8:00 - 9:00 a.m., on 12/4/15, both contained 5 tally marks and a "+" sign. It was not clear how many times Individual #3 engaged in the maladaptive behavior during the time period of 7:00 - 9:00 a.m.</p> <p>c. Individual #3's Behavior Log II data sheets, used for Decrease Slapping, Decrease Scratching and Pinching, Decrease Agitation, and Reduce Mounting Items programs, consisted of a grid with a column for each day of the week and a row for each hour time frame from 6:00 a.m. - 9:00 p.m. However, there was no indication where data was to be collected for the graveyard shift (10:00 p.m. - 6:00 a.m.).</p> <p>During an interview on 12/16/15 from 7:25 - 7:30 a.m., a graveyard staff stated individuals were rarely up during his shift, but stated it did happen</p>	W 252			

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND		STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 252	<p>Continued From page 28</p> <p>on occasion. The graveyard staff stated he had witnessed Individual #3 engage in maladaptive behavior and would follow the Plan Sheets, but stated he did not document maladaptive behaviors that occur on the graveyard shift.</p> <p>During an interview on 12/18/15 from 10:05 a.m. - 1:05 p.m., the QIDP and Program Director both stated they were not sure if the blank spaces were an absence of the identified behavior or a failure by staff to document. The Program Director and QIDP both stated staff were expected to document maladaptive behaviors on all shifts. The QIDP and Program Director both stated the tally mark data did not provide clear information about the maladaptive behavior, and stated they had not sought clarification from staff when reviewing the data.</p> <p>The facility failed to ensure Individual #3's behavioral data provided sufficient information to judge the efficacy of his programs.</p> <p>2. Individual #1's 1/20/15 IPP stated he was a 31 year old male whose diagnoses included profound mental retardation, cerebral palsy, GERD, and seizure disorder.</p> <p>Individual #1's Appropriate Social Contact Plan Sheet, dated 3/05, and Loud Vocalizations Plan Sheet, dated 2/04, both stated staff were to document tally marks for each occurrence of the behavior on a data sheet.</p> <p>Individual #1's Behavior Log II data sheets for both Appropriate Social Contact and Loud Vocalizations, from 8/1/15 - 12/16/15, were reviewed. The data sheets consisted of a grid with a column for each day of the week and a row</p>	W 252		

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND		STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 252	<p>Continued From page 29</p> <p>for each hour time frame from 6:00 a.m. - 9:00 p.m., creating a cell for each hour block. The majority of the cells were blank. Some cells contained 0's, and some cells had tally marks.</p> <p>For example, the 10/31/15 column for Appropriate Social Contact was blank. However, the 11/5/15 column documented the following:</p> <ul style="list-style-type: none"> - 6-7 a.m.: an "X" - 7-8 a.m.: a "2" - 8-9 a.m.: a "0" - 9-10 a.m.: a "0" - 10-11 a.m.: a "D2" - 11 a.m. - 12 p.m.: a "0" - 12-1 p.m.: a "1" - 1-2 p.m.: a "0" - 2-3 p.m.: a "0" - 3-4 p.m.: a "0" - 4-5 p.m.: a "D1" - 5-6 p.m.: a "0" - 6-7 p.m.: a "0" - 7-8 p.m.: a "0" - 8-9 p.m.: a "1" <p>It was not clear if the behavior was not evident on 10/31/15, or if staff failed to complete documentation for the day. Additionally, the data for 11/5/15 provided no information related to the "X," the "D2" or the "D1."</p> <p>During an interview on 12/18/15 from 10:05 a.m. - 1:05 p.m., the QIDP and Program Director both stated they were not sure if the blank spaces were an absence of the identified behavior or a failure by staff to document. The QIDP and Program Director both stated the tally mark data did not provide clear information about the maladaptive behavior, and stated they had not</p>	W 252		

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND		STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 252	<p>Continued From page 30</p> <p>sought clarification from staff when reviewing the data.</p> <p>3. Individual #2 was a 30 year old male with diagnoses including profound mental retardation, PICA and autism.</p> <p>a. Individual #2's Loud Vocalization Plan Sheet, dated 1/20/2015 stated staff were to document tally marks for each occurrence of the behavior.</p> <p>Individual #2's data sheets for Loud Vocalizations from 7/27/15 - 12/16/15, were reviewed. The data sheets consisted of a grid with a column for each day of the week and a row for each hour time frame from 12:00 a.m. - 11:00 p.m., creating a cell for each hour block. Numerous cells were blank. Some cells contained 0's, and some cells had tally marks and/or numbers.</p> <p>For example, no data was taken, during 142 days of the 142 day time period, from 10:00 p.m. - 5:00 a.m.</p> <p>Additionally, no data was taken from 5:00 p.m. - 10:00 p.m. for 56 days of the 142 day time period.</p> <p>b. Individual #2's data sheets for Excited Behavior at the day program site from 7/27/15 - 12/16/15, were reviewed. An ABC form had been used by staff to document Individual #2's excited behavior. However, the form was not used appropriately. Staff recorded the location of the behavior in the "Antecedent" column. Tally marks were documented in the "Behavior" column. The "Consequence Events" column contained either the words "sit down" or "redirect" with no further explanation as to how staff intervened or how Individual #2 responded.</p>	W 252		

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND			STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 252	Continued From page 31	W 252		
W 259	<p>During an interview on 12/18/15 from 10:05 a.m. - 1:05 p.m., the QIDP and Program Director both stated they were not sure if the blank spaces were an absence of the identified behavior or a failure by staff to document. The QIDP and Program Director both stated the tally mark data did not provide clear information about the maladaptive behavior, and stated they had not sought clarification from staff when reviewing the data.</p> <p>The facility failed to ensure Individual #2's behavioral data provided sufficient information to judge the efficacy of his programs.</p> <p>483.440(f)(2) PROGRAM MONITORING & CHANGE</p> <p>At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure comprehensive functional assessments were updated annually, or as needed, to accurately reflect the current status/needs for 2 of 3 individuals (Individuals #1 and #2) whose records were reviewed. This resulted in the potential for individuals' needs not to be addressed and for their record to not be an accurate reflection of their current status. The findings include:</p> <p>1. The facility used a CFA for individuals addressing seven categories of development including Personal Care, Sensorimotor,</p>	W 259	<p>W259 Corrective Action: A CFA will be completed 30 days prior to annual staffing.</p> <p>Identify Others Potentially Affected: All individuals in the home.</p> <p>System Change: Program Director will review complete record before TTX meeting. "Are all assessments and evaluations current? Y N" has been added to annual review face sheet.</p> <p>Monitoring: Please refer to W214</p> <p>Completion Date: January 21, 2016</p>	

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND		STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 259	<p>Continued From page 32</p> <p>Independent Living, Cognitive Skills, Speech and Language, Affective Development and Social Skills. Each of these categories assessed the capability of the individual to perform specific tasks using a scoring system 0 - 5, with 0 indicating the inability of the individual to perform the task and 5 indicating the individual's ability to perform the task independently.</p> <p>The directions for use of the facility CFA stated "In order to develop an appropriate service plan and address the needs of an individual a functional assessment needs to be completed... It provides an initial baseline of the person's skills and allows a comparison of abilities and needs from year to year."</p> <p>The facility failed to utilize this CFA form as a basis for changing programs as follows:</p> <ul style="list-style-type: none"> - Individual #2 was a 30 year old male with diagnoses including profound mental retardation, PICA and autism. His current IPP was dated 1/20/2015. - Individual #1 was a 31 year old male with diagnoses including profound mental retardation. His current IPP was dated 1/20/2015. <p>However, both Individuals #1 and #2's most current CFAs were dated January, 2014.</p> <p>In an interview on 12/17/15 from 10:05 a.m. - 1:05 p.m., the Program Director confirmed Individuals #1 and #2's CFAs had not been reviewed by the IDT since January, 2014. She said programs were updated on a yearly basis but assessments were not done annually and did not drive the revision of programs.</p>	W 259		

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND			STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 266	<p>488.450 CLIENT BEHAVIOR & FACILITY PRACTICES</p> <p>The facility must ensure that specific client behavior and facility practices requirements are met.</p> <p>This CONDITION is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure techniques used to manage inappropriate behavior were sufficiently developed, consistently implemented, and closely monitored. This failure resulted in individuals not receiving appropriate behavioral services and interventions. The findings include:</p> <ol style="list-style-type: none"> 1. Refer to W214 as it relates to the facility's failure to ensure behavioral needs were assessed. 2. Refer to W237 as it relates to the facility's failure to ensure behavior programs specified the form and frequency of data necessary to be able to assess individuals' progress toward meeting objectives. 3. Refer to W239 as it relates to the facility's failure to ensure replacement behavior training was appropriate to address individuals' maladaptive behaviors. 4. Refer to W252 as it relates to the facility's failure to ensure sufficient data was collected to determine the efficacy of individuals' intervention strategies. 5. Refer to W274 as it relates to the facility's 	W 266			

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND			STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 266	Continued From page 34 failure to ensure the behavior policy was appropriately implemented to address an individual's maladaptive behavior. 6. Refer to W288 as it relates to the facility's failure to ensure interventions were used only as directed by behavioral programs. 7. Refer to W312 as it relates to the facility's failure to ensure drugs to modify an individual's maladaptive behavior were sufficiently incorporated into a plan.	W 266	W266 Please refer to W159 Please refer to W214 Please refer to W239		
W 274	483.450(b)(1) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The facility must develop and implement written policies and procedures that govern the management of inappropriate client behavior. This STANDARD is not met as evidenced by: Based on observation, review of the facility's behavior policy, record review and staff interview, it was determined the facility failed to ensure the behavior policy was sufficiently implemented to govern the management of maladaptive behaviors which directly impacted 1 of 1 individual (Individual #3) and had the potential to impact 4 of 4 individuals (Individuals #1 - #4) residing at the facility. This resulted in a lack of sufficient assessment information, appropriate interventions, and adequate data to support the behavioral interventions used to address an individual's maladaptive behavior. The findings include: The facility's Behavior Management Policy, dated 10/1/03, stated the purpose and function of the policy was to "protect the clients from undue restrictions and control, resulting from the use of	W 274	W274 Please refer to W159 Please refer to W214 Please refer to W239		

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND			STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 274	<p>Continued From page 35</p> <p>behavior management techniques." The policy stated "Prior to the implementation of any behavior management program, a Functional Analysis will be completed by staff who know the individual well. The functional analysis will explore reasons for the behavior, including medical issues, communication, the environment, other people, etc.. [sic]"</p> <p>The policy stated "each behavior management program will be the least intrusive possible and will have the following features:"</p> <ul style="list-style-type: none"> - "Documentation that a behavior exists which compromises the client's residential and/or community placement and evidence that the behavior has not been amenable to informal techniques:" - "Documentation as to the current level or state of the targeted behavior (i.e., baseline) including specification of situations that result in the behavior and identification of the possible purpose or function that the behavior has for the client;" - "A functional, observable definition of the behavior;" - "An objective which specifies the current level of the behavior, the desired level of the behavior and the duration that the desired level must be maintained before the behavior management program can be withdrawn;" - "A written methodology emphasizing target hardening techniques, early detection and interruption, and consequence [sic] of the targeted behavior; and" 	W 274			

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND			STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 274	<p>Continued From page 36</p> <p>- "Consistent and reliable method of documenting, monitoring and reviewing the progress of the client's behavior."</p> <p>The policy was not sufficiently implemented, as follows:</p> <p>1. Individual #3's 9/24/15 IPP stated he was a 24 year old male whose diagnoses included severe mental retardation, TBI, cortical blindness, cerebral palsy and a history of seizures. He was admitted to the facility on 7/31/15.</p> <p>a. Individual #3's IPP stated he engaged in aggression (defined as hitting, slapping, pinching, scratching, and biting others). Section 4 of the IPP stated he received Trileptal (an anticonvulsant drug) and clonidine (an antihypertensive drug) to assist with aggression (exhibited as slapping, pinching, scratching, and biting).</p> <p>i. Individual #3's record did not include clear assessment information, as follows:</p> <p>Section 4 of the IPP stated he had experienced constipation in the past, which was believed to have increased his aggression, but provided no additional information related to potential causes or functions of the behavior.</p> <p>Individual #3's CFA, dated 11/15, included a statement "Is respectful of others (is not aggressive towards others, does not cause injury to others)." The statement was scored "0," meaning "Is dependent on full physical assistance to perform step in skill..." No additional information was present in the CFA regarding</p>	W 274			

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND			STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 274	<p>Continued From page 37 Individual #3's aggression.</p> <p>Individual #3's record included 2 Plan Sheets related to behaviors defined as aggression. His Plan Sheet for Decrease Slapping, revised 1/2015, stated Individual #3 "often slaps others to get out of things, to get attention, and sometimes just out of habit or routine." His Plan Sheet for Decrease Scratching and Pinching, undated, stated Individual #3 would scratch or pinch others when demands were placed on him, when asked to do something he did not want to do, or when he wanted to get out of things.</p> <p>Both plans included directions to staff to body position and provide increased assistance to complete the task if Individual #3 was attempting to get out of an activity, and to not respond if the behavior was for another purpose.</p> <p>Individual #3's CFA, the IPP and Plan Sheets did not include assessment information indicating how to determine if Individual #3 was engaging in the behavior for task avoidance as opposed to attention seeking behavior, or due to habit or routine.</p> <p>Individual #3's record did not provide a clear assessment of the purpose or function of his aggression.</p> <p>ii. Individual #3's record did not include appropriate data collection, as follows:</p> <p>Individual #3's record included two separate Plan Sheets to address behaviors defined as aggressive.</p> <p>- Individual #3's Plan Sheet for Decrease</p>	W 274			

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND			STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 274	<p>Continued From page 38</p> <p>Slapping, revised 1/2015, stated staff were to "Record a tally mark for each occurrence of [Individual #3] slapping others on the Behavior Log II data sheet." The Plan Sheet stated each episode could include slapping others or items such as tables, walls, or other objects.</p> <p>Individual #3's Behavior Log II for "Reduce Slapping" consisted of a grid with a column for each day of the week and a row for each hour time frame from 6:00 a.m. - 9:00 p.m.</p> <p>However, the tally data did not provide information related to the maladaptive behavior that would show what was happening prior to the incident, the actual behaviors that were observed (slapping others or slapping an object), what interventions staff provided (body positioning or ignoring), or how Individual #3 responded to the interventions.</p> <p>- Individual 3's Plan Sheet for Decrease Scratching and Pinching stated "Document each episode on behavior log 1. Be sure to be specific whether scratching or pinching."</p> <p>Individual #3's Behavior Log I for Decrease Scratching and Pinching consisted of a form with columns for date, time and staff initials. There were three additional columns labeled Antecedent Event (A), Behavior (B), and Consequent Events (C). The Behavior Logs were reviewed from 8/1/15 - 12/17/15. The data for December 2015 did not include sufficient information to evaluate the efficacy of the interventions. Examples included, but were not limited to, the following:</p> <p>- 9/3/15 at 5:30 p.m.: A - staff documented "Dinner." B - "Pinch." C - "Redirected to eat."</p>	W 274			

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND			STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 274	<p>Continued From page 39</p> <p>- 10/30/15: Under time, staff documented "6-9 am." A - "All morning." B - "Pinched/scratch/biting/hitting [sic]." C - "interrupted redirect [sic]."</p> <p>- 12/16/16: Under time, staff documented "8-9." A - "Breakfst [sic]." B - "Scratching staff." C - "Redirected."</p> <p>The data did not provide a clear description of the events related to the behavior (what happened directly before, the number of pinches/scratches, what redirection was used, Individual #3's response to the redirection, etc.). Additionally, it was not clear if the behavior was continuous for those incidents where a time block (e.g. 6-9 or 8-9) was listed.</p> <p>The data was not sufficient to indicate staff had implemented the Behavior Plan Sheet as written (body position and provide increased assistance to complete the task or not respond).</p> <p>During an interview on 12/18/15, the QIDP and Program Director both stated the data was not sufficient to demonstrate if or how Individual #3's behavior plan was followed, or if the interventions were effective.</p> <p>The data did not provide consistent and reliable information to monitor and review Individual #3's progress related to aggression. The facility would not be able to provide accurate information to Individual #3's psychiatric provider for use in making decision related to medications prescribed to address the behavior.</p> <p>iii. Individual #3's record did not include training</p>	W 274			

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND			STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 274	<p>Continued From page 40 for functional replacement behaviors, as follows:</p> <p>- His Decrease Slapping Plan Sheet stated Individual #3 "often slaps others to get out of things, to get attention, and sometimes just out of habit or routine."</p> <p>However, Individual #3's record did not include training for functionally related replacement behaviors such as seeking attention appropriately, or appropriate ways to get out of an activity.</p> <p>- His Decrease Scratching and Pinching Plan Sheet stated Individual #3 would scratch and pinch "when he is very agitated over someone attempting to get him to do something he does not want to do..." or "...to get out of things."</p> <p>However, Individual #3's record did not include training for functionally related replacement behaviors, such as refusing a task appropriately, or appropriate ways to get out of an activity.</p> <p>During an interview on 12/18/15 from 10:05 a.m. - 1:05 p.m., the Program Director stated replacement behavior training needed to be developed.</p> <p>The facility failed to ensure a comprehensive functional analysis of Individual #3's aggressive behavior had been completed as per policy. Additionally, there was a lack of clear program direction, a lack of replacement behavior training, and a lack of adequate data upon which to make program and medication change decisions.</p> <p>b. Individual #3's IPP stated he engaged in agitation (defined as yelling or swearing). Section</p>	W 274			

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND			STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 274	<p>Continued From page 41</p> <p>4 of the IPP stated he received Trileptal (an anticonvulsant drug) and clonidine (an antihypertensive drug) to assist with agitation (exhibited as yelling and screaming).</p> <p>i. Individual #3's record did not include clear assessment information, as follows:</p> <p>Individual #3's IPP provided no additional information related to potential causes or functions of the behavior.</p> <p>Individual #3's CFA, dated 11/2015, included a statement "Is respectful of others activities (does not interfere or interrupt...through yelling, screaming...)." The statement was scored "0." No additional information was present in the CFA regarding his agitation.</p> <p>Individual #3's Plan Sheet for Decrease Agitation, dated 2/2015, stated he would yell and/or swear when demands were placed on him, around meal times, to get out of things he didn't want to do, to get attention, and out of habit or routine. The Plan Sheet stated staff were to continue the activity and increase assistance if he was trying to get out of an activity, and were to leave the situation or not respond if he was agitated to get attention or out of habit or routine.</p> <p>Individual #3's CFA, the IPP and Plan Sheet did not include assessment information indicating how to determine if Individual #3 was engaging in the behavior for task avoidance as opposed to attention seeking behavior, or due to habit or routine. Additionally, no assessment information was present as to why Individual #3 engaged in the behavior around meal times (e.g., issues related to meal preparation, not wanting to remain</p>	W 274			

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND			STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 274	<p>Continued From page 42 at the table, difficulty with the environment around meals, dietary issues, etc.).</p> <p>Individual #3's record did not provide a clear assessment of the purpose or function of his agitation.</p> <p>ii. Individual #3's record did not include appropriate data collection, as follows:</p> <p>Individual #3's Plan Sheet for Decrease Agitation stated staff were to record tally mark data for each occurrence on the Behavior Log II data sheet.</p> <p>Individual #3's Behavior Log II for "Decrease Agitation" consisted of a grid with a column for each day of the week and a row for each hour time frame from 6:00 a.m. - 9:00 p.m.</p> <p>However, the tally data did not provide information related to the maladaptive behavior that would show what was happening prior to the incident, the actual behaviors that were observed (yelling or swearing), the function of the behavior (response to demands, meals, to avoid a task, to get attention, or out of habit or routine), what interventions staff provided (body positioning or ignoring), or how Individual #3 responded to the interventions.</p> <p>Additionally, there was no indication where data was to be collected for the graveyard shift (10:00 p.m. - 6:00 a.m.).</p> <p>During an interview on 12/16/15 from 7:25 - 7:30 a.m., a graveyard staff stated individuals were rarely up during his shift, but stated it did happen on occasion. The graveyard staff stated he had</p>	W 274			

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND			STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 274	<p>Continued From page 43</p> <p>witnessed Individual #3 engage in maladaptive behavior and would follow the Plan Sheets, but stated he did not document maladaptive behaviors that occur on the graveyard shift.</p> <p>During an interview on 12/18/15, the QIDP and Program Director both stated the data was not sufficient to demonstrate if or how Individual #3's behavior plan was followed, or if the interventions were effective. The QIDP and Program Director both stated data should be collected on all shifts.</p> <p>The data did not provide consistent and reliable information to monitor and review Individual #3's progress related to agitation. The facility would not be able to provide accurate information to Individual #3's psychiatric provider for use in making decision related to medications prescribed to address the behavior.</p> <p>iii. Individual #3's record did not include training for functional replacement behaviors, as follows:</p> <p>Individual #3's Decrease Agitation Plan Sheet stated "The intent of this program is to teach [Individual #3] to express himself quietly using appropriate means of communication."</p> <p>However, the initial instructions provided to staff under the "Decrease" section stated "Do not talk with [Individual #3] at this time, continue with task." If the behavior increased in intensity, staff were instructed to "Offer [Individual #3] a break in room to find an activity to assist calming him."</p> <p>It was not clear how not talking to Individual #3, or offering him a break in his room, would meet his need to use appropriate means of communication.</p>	W 274			

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND			STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 274	<p>Continued From page 44</p> <p>During an interview on 12/18/15 from 10:05 a.m. - 1:05 p.m., the Program Director stated Individual #3's behavior methods needed to be revised.</p> <p>Individual #3's Decrease Agitation Plan Sheet did not include appropriate interventions to address his maladaptive behavior.</p> <p>The facility failed to ensure a comprehensive functional analysis of Individual #3's agitation had been completed as per policy. Additionally, there was a lack of clear program direction, a lack of appropriate intervention, and a lack of adequate data upon which to make program and medication change decisions.</p> <p>c. Individual #3's IPP stated he engaged in mouthing items (defined as chewing on clothing or paper products).</p> <p>i. Individual #3's record did not include clear assessment information, as follows:</p> <p>Individual #3's IPP stated Individual #3 averaged less than one episode a week of mouthing objects. However, no additional information related to the function of the behavior was present.</p> <p>Individual #3's CFA did not include information related to the function of mouthing items.</p> <p>Individual #3's Plan Sheet for Reduce Mouthing Items, undated, did not include information related to the function or cause of the behavior.</p> <p>ii. Individual #3's record did not include appropriate data collection, as follows:</p>	W 274			

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND			STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 274	<p>Continued From page 45</p> <p>Individual #3's Plan Sheet for Reduce Mouthing Items, undated, stated staff were to "record a tally for any episodes of the hourly data sheet provided."</p> <p>Individual #3's Behavior Log II for "Reduce Mouthing Items" consisted of a grid with a column for each day of the week and a row for each hour time frame from 6:00 a.m. - 9:00 p.m.</p> <p>However, the tally data did not provide information related to the maladaptive behavior that would show what was happening prior to the incident, what item was mouthed, or how Individual #3 responded to the redirection.</p> <p>The facility failed to ensure an accurate and clear functional analysis of Individual #3's mouthing behavior had been completed as per policy. Additionally, there was a lack of adequate data upon which to make program change decisions.</p> <p>d. An observation was conducted on 12/14/15 from 3:25 - 4:30 p.m. At 3:25 p.m., Individual #3 struck the sides of his head with cupped hands no fewer than 2 times in rapid succession. The head hits created a noise but not leaving visible marks or injury. Individual #3 repeated the pattern of striking his head 2-3 times at 5-10 minute intervals.</p> <p>During the 65 minute observation, Individual #3 was observed to strike his head no less than 18 times. However, at no time were staff observed to intervene to interrupt the head hits.</p> <p>i. The observed behavior had not been addressed, as follows:</p>	W 274			

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND			STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 274	<p>Continued From page 46</p> <p>During an interview on 12/18/15 from 10:05 a.m. - 1:05 p.m., the Program Director and QIDP both stated Individual #3's behaviors appeared to be related to sensory issues.</p> <p>Individual #3's Occupational Therapy Assessment, dated 10/25/07, recommended the use of deep pressure through the larger joints, a trial of vibration, massage and blanket wrapping in order to help him calm. Additionally, the assessment included recommendations related to Individual #3's resistance to light touch.</p> <p>Attached to the assessment was a QMRP Consultant Report Review form, dated 11/14/07. The form stated "Desensitization program to touch is being addressed through body brushing program added to [Individual #3's] plan this past month and he is provided with a variety of hand held massagers to assist him to calm when agitated. The team discussed the use of deep pressure but felt that this was not appropriate at this time."</p> <p>Individual #3's IPP included an objective for Body Brushing. However, no other information related to Individual #3's sensory needs or the impact those needs may have on his maladaptive behavior and ability to calm were present in his IPP, CFA, or Plan Sheets.</p> <p>There was insufficient information present to assess the observed behaviors to explore the reasons for the behavior, the situations that resulted in the behavior, or the function of the behavior, as per the policy.</p> <p>and include specific situations that resulted in the</p>	W 274			

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND			STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 274	<p>Continued From page 47 behavior, or identify the possible purpose or function the behavior had.</p> <p>ii. There were no clear interventions present for Individual #3's head hits, as follows:</p> <p>Interviews were conducted on 12/16/15 from 7:25 - 7:45 a.m., with 3 DCS and the Home Manager. Each staff provided different interventions for Individual #3 when he engaged in head hits, as follows:</p> <ul style="list-style-type: none"> - DCS A stated he would place his hands between Individual #3's hands and head and gently direct Individual #3's hands to his sides. - DCS B stated he did not intervene when Individual #3 hit his head as he was never told to do so, and there were no written interventions for the behavior. - DCS C stated she would sometimes move Individual #3 to a quiet area or take him for a walk. - The Home Manager stated staff should block and redirect Individual #3's hands when he hit himself, but stated she did not believe the intervention was in a program. <p>There was no written plan related to Individual #3's head hits to direct staff and address early detection, interruption, or consequences for the behavior.</p> <p>iii. Data related to Individual #3's head hits was not being collected, as follows:</p> <p>Individual #3's record, including behavior data</p>	W 274			

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND		STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 274	<p>Continued From page 48 from 8/1/15 - 12/16/15, was reviewed. However, data related to his head hitting could not be found.</p> <p>Interviews were conducted on 12/16/15 from 7:25 - 7:45 a.m., with 3 DCS and the Home Manager with the following results:</p> <ul style="list-style-type: none"> - DCS A stated he worked the grave yard shift. DCS A stated he had witnessed Individual #3 striking his head when awake at night, but stated he did not document maladaptive behaviors on his shift. - DCS B stated Individual #3's head hits would be lumped into another maladaptive behavior. DCS B stated he did not document the head hits themselves. - DCS C and the Home Manager both stated head hits would only be documented if they resulted in a visible injury, and would then be documented on an injury form. <p>There was no method of documenting, monitoring, or reviewing Individual #3's head hits.</p> <p>During an interview on 12/18/15 from 10:05 a.m. - 1:05 p.m., the Program Director and QIDP both confirmed Individual #3 did not have an active treatment program related to head hits. The Program Director stated the behavior appeared to be sensory in nature, but stated no program or interventions had been developed to address the behavior.</p> <p>The facility failed to ensure a comprehensive functional analysis of Individual #3's head hits had been completed as per policy. Additionally,</p>	W 274		

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND			STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 274	Continued From page 49 there was a lack of program direction, a lack of appropriate intervention, and a lack of data upon which to make assessment and program decisions. e. Individual #3's "Behaviors of Note" data, from 8/1/15 - 12/16/15, was reviewed and documented no fewer than 7 incidents of taking his clothing off during maladaptive behaviors. However, assessment information related to the behavior could not be found. During an interview on 12/18/15 from 10:05 a.m. - 1:05 p.m., the Program Director and QIDP both stated new and emerging behaviors, such as the stripping, should be assessed. The Program Director and QIDP both stated the data had not been reviewed, so the emerging behavior had not been identified or addressed. The facility failed to ensure the behavior policy was sufficiently implemented to identify, assess, address, and evaluate the efficacy of the intervention strategies for Individual #3's maladaptive behaviors.	W 274			
W 288	483.450(b)(3) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview it was determined the facility failed to ensure techniques to manage inappropriate behavior were not used as a substitute for an	W 288	W288 Please refer to W159 Please refer to W214 Please refer to W239		

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND			STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 288	<p>Continued From page 50</p> <p>active treatment program for 1 of 3 individuals (Individual #3) whose records were reviewed. This resulted in behavioral interventions being utilized due to a lack of appropriate training programs. Findings include:</p> <p>1. Individual #3's 9/24/15 IPP stated he was a 24 year old male whose diagnoses included severe mental retardation, TBI, cortical blindness, cerebral palsy and a history of seizures. He was admitted to the facility on 7/31/15.</p> <p>An observation was conducted on 12/14/15 from 3:25 - 4:30 p.m. At 3:25 p.m., Individual #3 struck the sides of his head with cupped hands no fewer than 2 times in rapid succession. The head hits created a noise but not leaving visible marks or injury. Individual #3 repeated the pattern of striking his head 2-3 times at 5-10 minute intervals.</p> <p>During the 65 minute observation, Individual #3 was observed to strike his head no less than 18 times. However, at no time were staff observed to intervene to interrupt the head hits.</p> <p>Interviews were conducted on 12/16/15 from 7:25 - 7:45 a.m., and indicated the following:</p> <p>- DCS A stated he had witnessed Individual #3 engage in head hitting behavior, but had never seen injury or marks from the hits. DCS A stated he would typically block and redirect the strikes by placing his hands between Individual #3's hands and head and gently direct Individual #3's hands to his sides. DCS A stated he would call Individual #3's name during this process in order to get his attention, then try to distract him by turning up a radio.</p>	W 288			

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND			STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 288	<p>Continued From page 51</p> <p>- DCS B stated Individual #3 hit himself daily, but stated he did not document the head hits. DCS B stated the head hits were grouped into other behaviors, and stated he did not intervene when Individual #3 hit his head. When asked why he did not intervene, DCS B stated he was never told to and had never seen written interventions for the behavior. DCS B stated he had never seen Individual #3 leave an injury or mark from hitting himself in the head.</p> <p>- DCS C stated she only filled in at the facility and worked more with Individual #3 at his day program. DCS C stated she had only seen Individual #3 strike himself in the head a couple of times at the day program, but had never seen the behavior at the facility. DCS C stated she would sometimes move Individual #3 to a quiet area when he struck himself, or would sometimes take him for a walk. DCS C stated she had never provided any physical intervention for the head hits.</p> <p>- The Home Manager stated Individual #3 would hit himself when he was agitated, and would generally hit 1-2 times, pause, then hit himself again. The Home Manager stated the behavior occurred most days, and was generally seen between 11:30 a.m. - 4:30 p.m. The Home Manager stated staff should block and redirect Individual #3's hands when he hit himself, but stated she did not believe the intervention was in a program.</p> <p>Individual #3's record was reviewed and did not include interventions or directions to staff related to head hits. Without an appropriate active treatment program related to head hits, staff were</p>	W 288			

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND			STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 288	Continued From page 52 left to determine what, if any, interventions should be used to address Individual #3's head hits. During an interview on 12/18/15 from 10:05 a.m. - 1:05 p.m., the Program Director and QIDP both confirmed Individual #3 did not have an active treatment program related to head hits. The Program Director stated the behavior appeared to be sensory in nature, but stated no program or interventions had been developed to address the behavior. The facility failed to ensure techniques implemented by staff to manage Individual #3's head hits were not due to a lack of an appropriate active treatment program designed to address the behavior.	W 288			
W 312	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure behavior modifying drugs were used only as a comprehensive part of individuals' program plans that were directed specifically towards the reduction of, and eventual elimination of, the behaviors for which the drugs were employed for 1 of 3 individuals (Individual #2) whose medication reduction plans were reviewed. This resulted in individuals receiving behavior	W 312			

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND			STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 312	<p>Continued From page 53</p> <p>modifying drugs without plans that identified the drug usage and how it may change in relation to progress or regression. The findings include:</p> <p>1. Individual #2 was a 30 year old male with diagnoses including profound mental retardation, PICA and autism.</p> <p>Review of his record showed a restrictive consent, dated 5/19/15, for Lorazepam (an anti anxiety drug) to be taken prior to dental appointments.</p> <p>The consent described the need for the medication as "[Individual #2] will make constant movements attempting to forcefully push dental assistants [sic] hands away from his mouth, rarely lays his head back and will jerk head upright rapidly during dental examination. He will also attempt to get out of the dental chair during exam." The consent went on to say "[Individual #2] is currently participating in a Brush Teeth program to assist with dental examinations."</p> <p>His IPP, dated 1/20/15, stated under "Current Reduction Plan," Individual #2 would be assisted at dental appointments to be comfortable and participate. The plan stated the medication would be reduced when Individual #2 participated in treatment at 6 consecutive dental appointments.</p> <p>Individual #2's IPP included a tooth brushing program with a stated objective "Given the need to increase his ability to brush his teeth independently, [Individual #2] will brush his teeth with 80% independence for 15 consecutive days."</p> <p>Individual #2's toothbrushing program did not address the issues of participating in dental visits</p>	W 312	<p>W312</p> <p>Corrective Action: Dental desensitization program is standard when medication is given before a dental appointment. The new house manager assumed the tooth brushing program was sufficient. She has received instruction to correct this oversight.</p> <p>Identify Other Potential Effectuated: Individual #2.</p> <p>System Change: Please see Corrective Action</p> <p>Monitoring: Program Director will monitor QIDP plans for all individuals with med reduction programs during monthly QIDP meeting.</p> <p>Completion Date: January 21, 2016</p>		

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND			STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 312	Continued From page 54 by not pushing others hands away, laying his head back, head jerking, or leaving the dental chair.	W 312			
W 329	In an interview on 12/18/15 from 10:05 a.m. - 1:05 p.m., the Program Director confirmed the lack of a dental desensitization program for Individual #2 and said a program should have been developed to work toward eliminating the restrictive medication. The facility failed to Individual #2's Lorazepam was sufficiently incorporated into a plan. 483.460(b)(1) PHYSICIAN PARTICIPATION IN THE IPP A physician must participate in the establishment of each newly admitted client's initial individual program plan as required by §456.380 of this chapter that specifies plan of care requirements for ICFs. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure medical status was assessed by a physician and incorporated into the IPP for 1 of 1 individual (Individual #3) who was admitted to the facility within the last year. This resulted in the potential for the individual to not receive all necessary services. The findings include: 1. Individual #3's 9/24/15 IPP stated he was a 24 year old male whose diagnoses included severe mental retardation, TBI, cortical blindness, cerebral palsy and a history of seizures. He was	W 329			

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND			STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 329	Continued From page 56 admitted to the facility on 7/31/15 from a sister facility within the same company. Individual #3's medical record contained an H&P, dated and signed by a physician on 9/30/15. His IPP was dated 9/24/15. During an interview on 12/17/15 from 10:05 a.m. - 1:05 p.m., the Program Director confirmed a physician assessment had not been done prior to the development of an initial IPP for Individual #3. The facility failed to ensure a physician participated in Individual #3's initial IPP.	W 329	W329 Please refer to W210	
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. ✓ This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure adequate nursing services were provided to individuals. This failure directly impacted 1 of 4 individuals (Individual #1) whose injury reports were reviewed, and had the potential to impact all individuals (Individuals #1 - #4) residing at the facility. This resulted in a lack of adequate systems being developed and implemented necessary to ensure individuals were appropriately monitored after sustaining head injuries. The findings include: 1. Individual #1 was a 31 year old male with diagnoses including profound mental retardation, grand mal seizures, and complex partial seizures.	W 331	W331 Corrective Action: Head injury protocol has been revised. See attached policy. LPN will in service staff and instructions will be included in our new hire class. Identify Others Potentially Affected: All individuals at this home. System Changes: Please see Corrective Action. Monitoring: Completed head injury monitoring form will be faxed to office for LPN and house manager will check form during 3x data sheet check see W159. Completion Date: January 21, 2016	

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND			STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 331	<p>Continued From page 56</p> <p>An Injury Report, dated 6/5/15, documented Individual #1 experienced a fall during seizure activity. The form included a section where check marks could be placed to body areas indicating possible injury. Check marks had been placed indicating potential injury to Individual #1's left upper arm, elbow, lower arm, ribs, hip, knee, and lower leg. Staff did not indicate a head injury had occurred.</p> <p>The form showed nursing had been notified on 6/5/15, time unknown. The area on the form marked "Nurse gave phone orders?" had been left blank. The form documented no first aid had been given. No documentation of staff monitoring Individual #1's condition after the fall was found.</p> <p>The facility's CNA signed the form the following day, on 6/6/15, stating "No noted injury at this time. No signs or symptoms of head injury. No tx [treatment] needed." The injury report was not clear regarding whether or not Individual #1 had hit his head during the fall on 6/5/15. The House Manager signed the form on 6/6/15, and the LPN signed the form on 6/10/15.</p> <p>The facility's system for monitoring head injuries was reviewed. A document titled Signs of Head Injury, undated, was reviewed. The document listed 10 potential signs/symptoms of a head injury including change in consciousness or behavior, blood or other fluid in the ears or nose, and unequal or dilated pupils. The document then instructed staff to page the nurse if any of the 10 symptoms were observed. However, it did not instruct staff how or when to evaluate an individual using the list of symptoms.</p>	W 331			

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND			STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 331	Continued From page 57 The HCPro Long Term Care Nursing Library [www.HCPro.com, accessed 12/28/15], included a 1/8/2013 article that recommended monitoring for a minimum of 72 hours following a head injury with neurological assessment every 15 minutes for two hours, then every 30 minutes for two hours, then every 60 minutes for four hours, then every eight hours until at least 72 hours have elapsed and the individual is stable. The recommendation defined a neurological assessment as including (at a minimum) pulse, respiration, blood pressure, pupil size and reactivity, and equality of hand grip strength. In an interview on 12/18/15 from 10:05 a.m. - 1:05 p.m., the Program Director and the LPN stated there was no other tool used to evaluate individuals who had sustained a head injury. The facility failed to ensure nursing staff provided adequate instruction to staff when monitoring individuals with potential head injuries.	W 331			
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to administer drugs as ordered by the physician for 1 of 3 individuals (Individual #3) whose physician's orders were reviewed. This resulted in an individual receiving medications not consistent with a physician's order. The findings	W 368			

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND			STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 368	<p>Continued From page 58</p> <p>include:</p> <p>Individual #3's 9/24/15 IPP stated he was a 24 year old male whose diagnoses included severe mental retardation, TBI, cortical blindness, cerebral palsy, a history of seizures, and acne.</p> <p>His record documented a physician's order, dated 5/1/15, for Triamcinolone 0.1% cream (a corticosteroid drug) to be applied to both hands for eczema, "every other day when doing well and once daily when flaring."</p> <p>Individual #3's MARs showed he had received the medication during 8/2015, 9/2015, and the first week of 10/2015 twice a day, every other day.</p> <p>On 10/8/15 the physician ordered the medication to be applied prn (as needed).</p> <p>On 10/8/15 the MAR indicated Individual #3 stopped receiving the medication.</p> <p>The 11/2015 MAR indicated Individual #3 received the medication twice a day, every day, for the entire month.</p> <p>Additionally, an H&P, signed by Individual #3's primary care physician on 9/30/15, showed the medication as Triamcinolone Acetonide 0.5% topical cream, which was a change in dosage.</p> <p>In an interview on 12/17/15 from 10:05 a.m. - 1:05 p.m., the Program Director and the LPN confirmed the discrepancies between Individual #3's MARs and physicians' orders. They said the medication had been administered incorrectly.</p> <p>The facility failed to administer medication as</p>	W 368	<p>W368</p> <p>Corrective Action: The LPN compares MARs with doctor orders at the end of the month before current months med are put in the home.</p> <p>Identify Others Potentially Affected: No other errors were found.</p> <p>System Changes: This was an oversight and no system changes are indicated.</p> <p>Monitoring: We will continue to check current orders against medication flow sheets and pharmacy label before 1st of month.</p> <p>Completion Date: January 21, 2016</p>	

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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/21/2015
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND			STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 368	Continued From page 59 ordered by the physician to an individual.	W 368			

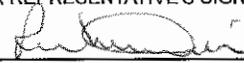
Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/21/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND	STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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 The following deficiencies were cited during the licensure survey conducted from 12/15/15 to 12/21/15. The surveyors conducting your survey were: Trish O'Hara, RN, Team Lead Michael Case, LSW, QIDP	M 000		
MM080	16.03.11100 Governing Body and Management 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. This Rule is not met as evidenced by: Refer to W114.	MM080	refer to W114	
MM134	16.03.11200 Client Protections The requirements of Sections 200 through 299 of these rules are modifications and additions to the requirements in 42 CFR 483.420 - 483.420(d)(4), Condition of Participation: Client Protections incorporated in Section 004 of these rules. This Rule is not met as evidenced by: Refer to W154.	MM134	Please refer to W154	
MM155	16.03.11300 Facility Staffing The requirements of Sections 300 through 399 of	MM155		

RECEIVED
JAN 15 2016
FACILITY STANDARDS

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>President</i>	(X6) DATE <i>1/15/16</i>
--	---------------------------	-----------------------------

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/21/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVEL	STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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
MM155	Continued From page 1 these rules are modifications and additions to the requirements in 42 CFR 483.430 - 483.430(e)(4), Condition of Participation: Facility Staffing incorporated in Section 004 of these rules This Rule is not met as evidenced by: Refer to W159.	MM155	<i>Please refer to W159</i>	
MM159	16.03.11400 Active Treatment Services The requirements of Sections 400 through 499 of these rules are modifications and additions to the requirements in 42 CFR 483.440 - 483.440(f)(4), Condition of Participation: Active Treatment Services incorporated in Section 004 of these rules. This Rule is not met as evidenced by: Refer to W210, W214, W224, W237, W239, W252 and W259.	MM159	<i>Please refer to W210, W214, W224, W237, W239, W252, W259</i>	
MM162	16.03.11500 Client Behavior and Facility Practices The requirements of Sections 500 through 599 of these rules are modifications and additions to the requirements in 42 CFR 483.450 - 483.450(e)(4) (iii), Condition of Participation: Client Behavior and Facility Practices incorporated in Section 004 of these rules. This Rule is not met as evidenced by: Refer to W266, W274, W288, and W312.	MM162	<i>Please refer to W266, W274, W288, W312</i>	
MM166	16.03.11600 Health Care Services	MM166		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/21/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVEL	STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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
MM166	<p>Continued From page 2</p> <p>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.</p> <p>This Rule is not met as evidenced by: Refer to W329, W331 and W368.</p>	MM166	<p><i>please refer to W329, W331, W368</i></p>	