



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

TAMARA PRISOCK--ADMINISTRATOR  
DIVISION OF LICENSING & CERTIFICATION  
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BUREAU OF FACILITY STANDARDS  
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December 30, 2015

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

RE: Seven Oaks Community Homes - Pinnacle, Provider #13G075

Dear Mr. Silberberger:

This is to advise you of the findings of the Medicaid/Licensure survey of Seven Oaks Community Homes - Pinnacle, which was conducted on December 21, 2015.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

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

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

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

After you have completed your Plan of Correction, return the original to this office by **January 12, 2016**, and keep a copy for your records.

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

[www.icfmr.dhw.idaho.gov](http://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 12, 2016. If a request for informal dispute resolution is received after January 12, 2016, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



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: 12/29/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G075</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/21/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>SEVEN OAKS COMMUNITY HOMES - PINNACLE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3908 NORTH PINNACLE POST FALLS, ID 83854</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS  The following deficiency was cited during the recertification survey conducted from 12/15/15 to 12/21/15.  The surveyors conducting your survey were:  Trish O'Hara, RN, Team Lead Michael Case, QIDP	W 000		
W 382	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING  The facility must keep all drugs and biologicals locked except when being prepared for administration.  This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure all drugs and biologicals were maintained under locked conditions, which had the potential to impact 5 of 5 individuals (Individuals #1 - #5) residing at the facility. This resulted in the potential for harm in the event individuals accessed and ingested a drug. The findings include:  1. An observation was conducted at the facility on 12/15/15 from 3:25 - 4:25 p.m. During that time, the cabinet which contained medications for all 5 individuals residing at the facility was noted to be unlocked. As a result, all medications stored in the facility were unsecured.  The Facility Supervisor, who was present during the observation, stated the cabinet should have been locked. The Facility Supervisor stated the cabinet must have been left unlocked by accident	W 382	<i>Corrective Action:</i> The house manager will instruct staff to check locks after each time medication cabinets are opened. Disciplinary action will result in written warning and/or termination if further incidents occur.  Identify Others Potentially Affected: All in home.  System Change: Refer to corrective action.  Monitor: House manager, nurse.  Completion Date: January 31, 2016	<b>RECEIVED</b> <b>FEB -2 2016</b> <b>FACILITY STANDARDS</b>

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

TITLE

*President*

(X6) DATE

*1/31/2016*

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

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G075</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>12/21/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>SEVEN OAKS COMMUNITY HOMES - PINNACLE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3908 NORTH PINNACLE POST FALLS, ID 83854</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 382	Continued From page 1 during the last medication pass.  The facility failed to ensure all drugs were maintained under locked conditions.	W 382			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G075	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED  12/21/2015
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NAME OF PROVIDER OR SUPPLIER  SEVEN OAKS COMMUNITY HOMES - PINNACLE	STREET ADDRESS, CITY, STATE, ZIP CODE 3908 NORTH PINNACLE POST FALLS, ID 83854
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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M 000	16.03.11 Initial Comments  The following deficiency was 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, QIDP	M 000		
MM166	16.03.11600 Health Care Services  The requirements of Sections 600 through 699 of these rules are for modifications and additions to the requirements in 42 CFR 483.460 - 483.460(n) (2), Condition of Participation: Health Care Services incorporated in Section 004 of these rules.  This Rule is not met as evidenced by: Refer to W382.	MM166	refer to w382	

RECEIVED  
FEB - 2 2016  
FACILITY STANDARDS

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE President	(X6) DATE 1/31/16
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