



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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RICHARD M. ARMSTRONG – Director

TAMARA PRISOCK—ADMINISTRATOR  
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February 9, 2016

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

RE: Seven Oaks Community Homes - Tybalt, Provider #13G023

Dear Mr. Silberberger:

This is to advise you of the findings of the Medicaid/Licensure survey of Seven Oaks Community Homes - Tybalt, which was conducted on February 4, 2016.

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

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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 **February 22, 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 February 22, 2016. If a request for informal dispute resolution is received after February 22, 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,



MICHAEL CASE  
Health Facility Surveyor  
Non-Long Term Care



NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

MC/pmt  
Enclosures

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

PRINTED: 03/17/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G023	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  02/04/2016
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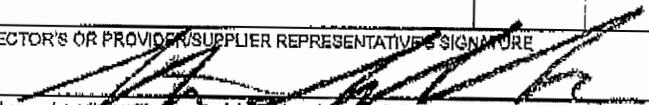
NAME OF PROVIDER OR SUPPLIER  SEVEN OAKS COMMUNITY HOMES - TYBALT	STREET ADDRESS, CITY, STATE, ZIP CODE 669 NORTH TYBALT POST FALLS, ID 83854
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS  The following deficiencies were cited during the annual recertification survey conducted from 2/2/16 - 2/4/16.  The surveyor conducting your survey was:  Michael Case, LSW, QIDP, Team Lead  Common abbreviations used in this report are:  DCS - Direct Care Staff IPP - Individual Program Plan LPN - Licensed Practical Nurse	W 000		
W 454	483.470(l)(1) INFECTION CONTROL  The facility must provide a sanitary environment to avoid sources and transmission of infections.  This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure infection control procedures were followed to prevent and control infection and/or communicable diseases, which directly impacted 2 of 5 individuals (Individuals #2 and #3) residing at the facility, and had the potential to impact all individuals (Individuals #1 - #5). That failure had the potential to provide opportunities for cross-contamination to occur and negatively impact individuals' health. The findings include:  1. Individual #2's 9/21/15 IPP stated he was a 63 year old male whose diagnoses included profound mental retardation.  During an observation on 2/3/16 from 6:05 - 7:15	W 454		

RECEIVED

MAR 28 2016

FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ADMINISTRATIVE	(X6) DATE 3/28/16
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER  SEVEN OAKS COMMUNITY HOMES - TYBALT			STREET ADDRESS, CITY, STATE, ZIP CODE 685 NORTH TYBALT POST FALLS, ID 83854	
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W 454	<p>Continued From page 1</p> <p>a.m., Individual #2 was observed to participate in a medication administration program. During that time, infection control concerns were noted, as follows:</p> <p>At 6:06 a.m., Individual #2 entered the medication administration area with DCS A. DCS A donned a pair of gloves, then obtained and prepared a blood glucose monitor for Individual #2. DCS A assisted Individual #2 to obtain a blood sample from his finger and apply it to the monitor. DCS A then disposed of the testing supplies and removed her gloves. DCS A was not observed to wash her hands.</p> <p>DCS A obtained one of Individual #2's blister packs, pierced the back of the blister with her fingernail, held the blister pack over a medication cup, and had Individual #2 punch the pill into the cup. DCS A repeated this process with each of Individual #2's 10 blister packs. It was noted DCS A had acrylic nails.</p> <p>The Centers for Disease Control website (<a href="http://www.cdc.com">www.cdc.com</a>, accessed 2/8/16), stated "Healthcare workers who wear artificial nails are more likely to harbor gram-negative pathogens on their fingertips than are those who have natural nails, both before and after handwashing."</p> <p>During an interview on 2/4/16 from 3:00 - 3:25 p.m., the Program Director and LPN both stated DCS A should have washed her hands after removing her gloves. The LPN stated DCS A should not have been puncturing the back of the blister packs with her nails.</p> <p>2. Individual #3's 9/14/15 IPP stated she was a 38 year old female whose diagnoses included</p>	W 454		

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NAME OF PROVIDER OR SUPPLIER  SEVEN OAKS COMMUNITY HOMES - TYBALT			STREET ADDRESS, CITY, STATE, ZIP CODE 669 NORTH TYBALT POST FALLS, ID 83854		
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W 454	<p>Continued from page 2 moderate mental retardation.</p> <p>During an observation on 2/3/16 from 3:00 - 4:35 p.m., Individual #3 was observed to participate in a medication administration program. During that time, infection control concerns were noted, as follows:</p> <p>At 4:10 p.m., Individual #3 entered the medication administration area with DCS B. After both Individual #3 and DCS B washed their hands, DCS B donned a pair of gloves and removed a dressing covering an open wound on the top of Individual #3's left hand.</p> <p>DCS B disposed of the dressing and removed her gloves. DCS B donned a new pair of gloves. However, she was not observed to wash her hands. DCS B then removed Individual #3's medication blister packs and clean dressing materials from the medication cabinet. DCS B was observed to change her gloves a second time, but did not wash her hands.</p> <p>DCS B cut a piece of gauze pad, removed her gloves and obtained hydrogen peroxide from the medication cabinet. DCS B mixed hydrogen peroxide with water in a medication cup. DCS B donned new gloves, but was not observed to wash her hands.</p> <p>DCS B cleaned the area on Individual #3's left hand with the hydrogen peroxide mixture, then applied triple antibiotic ointment and a new dressing. DCS B then changed her gloves, but was not observed to wash her hands.</p> <p>DCS B used her gloved hand to turn the pages in the medication administration record, ran her</p>	W 454			

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NAME OF PROVIDER OR SUPPLIER  SEVEN OAKS COMMUNITY HOMES - TYBALT			STREET ADDRESS, CITY, STATE, ZIP CODE 889 NORTH TYBALT POST FALLS, ID 83854		
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W 454	<p>Continued From page 3</p> <p>gloved hand down the page, then used her gloved finger to pierce the back of individual #2's medication blister pack. Her gloved finger was observed to come in contact with the pill in the blister pack. DCS B held the punctured blister over a medication cup, and individual #3 punched the pill into the cup.</p> <p>DCS B then removed her gloves and documented in the medication administration record. DCS B was not observed to wash her hands after removing her gloves.</p> <p>During an interview on 2/3/16 at 6:00 p.m., DCS B stated she had participated in a medication administration class. When asked about glove use, DCS B stated staff were trained to wrap one glove in the other when removing them, but was unable to describe when hand washing should take place in relation to glove use.</p> <p>During an interview on 2/4/16 from 3:00 - 3:26 p.m., the Program Director and LPN both stated DCS B should have washed her hands between glove changes.</p> <p>The facility failed to ensure appropriate infection control procedures were implemented.</p>	W 454	<p><u>W 454</u></p> <p>The facility nurse will review the infection control policy of the facility and will add detailed information as needed. The known areas of concern addressed will include: When engaged in a medical procedure, (including medication assistance) the staff will be trained when/how to wash hands properly; Also, will include training regarding when/how to don medical gloves and remove them properly; Improper ways to pierce bubble packs. The training will be provided to all staff and will be added to the facilities "Monthly Medical/Equipment Training Checklist" form to insure it is reviewed regularly with the staff; The information will be added to the new employee OSHA/Med class as well, to insure all new employees are initially trained. To insure routine monitoring of Infection control is completed, it will be added to the Managers TPS schedule.</p> <p>By whom: facility nurse Completion date: 4/1/2016</p>		

