



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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September 27, 2016

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

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

Dear Mr. Silberberger:

This is to advise you of the findings of the Medicaid/Licensure survey of Seven Oaks Community Homes - Elm, which was conducted on September 22, 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

Steve Silberberger, Administrator
September 27, 2016
Page 2 of 2

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

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

After you have completed your Plan of Correction, return the original to this office by **October 11, 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

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 October 9, 2016. If a request for informal dispute resolution is received after October 9, 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 the survey. If you have any questions, comments or concerns, please contact Dennis Kelly, RN or Nicole Wisenor, Co-Supervisors, Non-Long Term Care at (208) 334-6626, option 4.

Sincerely,



NICOLE WISENOR, Supervisor
Non-Long Term Care

NW/pmt
Enclosures

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

PRINTED: 09/26/2016
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G025	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/22/2016
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NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - ELM	STREET ADDRESS, CITY, STATE, ZIP CODE 630 NORTH ELM STREET POST FALLS, ID 83854
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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W 000	INITIAL COMMENTS The following deficiency was cited during the recertification survey conducted from 9/19/16 to 9/22/16. The survey was conducted by: Jim Troutfetter, QIDP, Common abbreviations used in this report are: IPP - Individual Program Plan LPN - Licensed Practical Nurse	W 000		
W 325	483.460(a)(3)(iii) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure routine screening laboratory examinations were provided to 1 of 3 individuals (Individual #1) whose medical records were reviewed. This resulted in the potential for medical concerns to go undetected. The findings include: 1. Individual #1's IPP, dated 6/28/16, documented he was a 50 year old male whose diagnoses included severe intellectual disability. His record contained an admission physical, dated 6/8/16. The Assessment/Plan section of the report documented Individual #1 was to	W 325		

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OCT 11 2016
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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[Signature] ADMINISTRATOR 10/6/16

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.

[Signature] ADMIN. 10/6/16

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

PRINTED: 09/26/2016
FORM APPROVED
OMB NO. 0938-0397

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G025	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/22/2016
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - ELM			STREET ADDRESS, CITY, STATE, ZIP CODE 630 NORTH ELM STREET POST FALLS, ID 83854		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 325	<p>Continued From page 1</p> <p>receive a urine analysis (UA) "... to be performed today."</p> <p>However, no documentation Individual #1 had received the UA could be found.</p> <p>During an interview on 9/21/16 at 12:25 p.m., the LPN stated he could not find documentation the UA had been completed and did not think the UA had been done.</p> <p>The facility failed to ensure Individual #1 received a UA as ordered.</p>	W 325	<p>W325 Corrective Action :</p> <p>The facility obtained an admission physical examination for a client; The M.D. exam notes a urine analysis was to be collected that day, but was never acquired. The day of the appointment the physician requested an attempt be made to collect a U/A, from the client. The staff were not successful and no further attempts were made or documented. The facility nurse will ensure all medical staff take the facility "Appointment Concerns" form to every appointment. The facility nurse will train the medical staff to document the need for the appt., what was discussed, and what was ordered by the M.D. (lab's, x-rays/ tests, treatments etc.) this will be used as a reminder to the medical staff to complete the task. The medical office staff often mail out the appointment dictation at a later date.</p> <p>The U/A has since been collected, tested and the M.D notified.</p> <p>Other residents affected: All residents in the home.</p> <p>Systemic changes: see corrective action</p> <p>Monitor: This was a 1x error.</p> <p>By Whom: Facility Nurse and Medical staff</p> <p>Completion Date: 10/05/2016</p>		

Bureau of Facility Standards

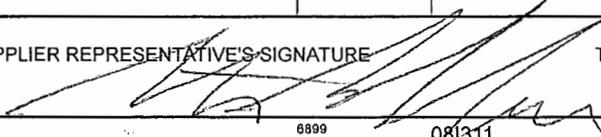
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M 000	16.03.11 Initial Comments The following deficiency was cited during the state licensure survey conducted from 9/19/16 to 9/22/16. The surveyor conducting your survey was: Jim Troutfetter, QIDP	M 000		
MM166	16.03.11600 Health Care Services The 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 W325.	MM166	MM 166 Please refer to W325	

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Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	ADMINISTRATOR	10/6/16

 ADMIN. 10/6/16