



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
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E-mail: fsb@dhw.idaho.gov

September 29, 2016

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

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

Dear Mr. Silberberger:

This is to advise you of the findings of the Medicaid/Licensure survey of Seven Oaks Community Homes - Stephanie, which was conducted on 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 29, 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 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

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 12, 2016. If a request for informal dispute resolution is received after October 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 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

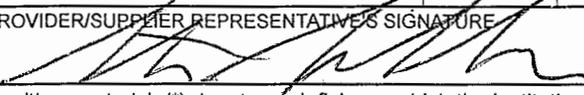
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/29/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G054	(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 - STEPHANIE	STREET ADDRESS, CITY, STATE, ZIP CODE 615 NORTH STEPHANIE 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
W 000	INITIAL COMMENTS The following deficiencies were cited during the recertification survey conducted from 9/19/16 to 9/22/16. The survey was conducted by: Jim Troutfetter, QIDP, Team Leader Common abbreviations used in this report are: AED - Anti-Epileptic Drug IPP - Individual Program Plan LPN - Licensed Practical Nurse	W 000		
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on record review and staff interview it was determined the facility failed to ensure sufficient information was provided to guardians related to alternative assessments for 2 of 3 individuals (Individuals #1 and #2) whose medical records were reviewed. This resulted in a lack of information being provided to individuals' guardians regarding alternatives and the possible consequences of refusal of bone mineral density assessments. The findings include:	W 124	<p style="text-align: right;">OCT 11 2016</p> <p style="text-align: center;">FACILITY STANDARDS</p> <p>W124 Corrective Action: The facility attempted to get DEXA scans on the two individuals in the plan of corrections, whom are both at high risk for osteoporosis. The testing was unsuccessful and the DEXA scan was noted, not recommended to be pursued in the future. The physician felt his current treatment was appropriate and did not wish to order alternative testing, so no further testing was attempted. Alternate testing information was not provided, allowing the guardians to make an informed decision. The facility's medical staff will inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, development and behavioral status, attendant risks of treatment, and of the right to refuse treatment. When medical tests are not successful and the M.D. gives no further recommendations, the facility medical staff will research alternative tests. They will then relay the information, including the pro's and con's to the appropriate person or party. This way the client, parent, or guardian will have the information to make an informed decision, whether to pursue further tests or treatment. Other residents affected: All residents in the home. Systemic changes: see corrective action plan.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ADMINISTRATOR	(X6) DATE 10/6/16
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A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her 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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CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0397

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/22/2016
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - STEPHANIE			STREET ADDRESS, CITY, STATE, ZIP CODE 615 NORTH STEPHANIE STREET POST FALLS, ID 83854	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 124	<p>Continued From page 1</p> <p>1. Individual #1's IPP, dated 1/13/16, documented a 42 year old male whose diagnoses included profound intellectual disability, cerebral palsy, and seizure disorder.</p> <p>His record also contained a document from a local medical center, dated 5/16/12, which documented they were unable to complete a DEXA scan "... due to pt [patient] disabilities and surgeries."</p> <p>However, no documentation of Individual #1's guardian being notified that the facility did not intend to continue bone mineral assessments or provide possible options to a DEXA scan could be found.</p> <p>During an interview on 9/22/16 from 11:05 a.m. - 12:10 p.m., the LPN stated options to a DEXA scan, such as a portable forearm bone density screening, had not been considered or discussed with the guardian for Individual #1.</p> <p>2. Individual #2's IPP, dated 7/28/16, documented a 29 year old male whose diagnoses included profound intellectual disability, cerebral palsy, and seizure disorder.</p> <p>His record contained a letter from a local health care provider, dated 5/16/12, which documented a DEXA scan was attempted, but could not be completed. It stated no further DEXA scans should be ordered in the future due to "hardware."</p> <p>However, no documentation of Individual #2's guardian being notified that the facility did not intend to continue bone mineral assessments or provide possible options to a DEXA scan could be found.</p>	W 124	<p>Monitor: Facility nurse will review annually while completing annual nursing summary.</p> <p>By Whom: Facility Nurse and Medical staff Completion Date: November 1st, 2016</p>	

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NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - STEPHANIE	STREET ADDRESS, CITY, STATE, ZIP CODE 615 NORTH STEPHANIE STREET POST FALLS, ID 83854
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W 124	Continued From page 2 During an interview on 9/22/16 from 11:05 a.m. - 12:10 p.m., the LPN stated options to a DEXA scan, such as a portable forearm bone density screening, had not been considered or discussed with the guardian for Individual #2. The facility failed to inform the guardians of Individuals #1 and #2 of possible assessment options related to bone mineral density assessments.	W 124		
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 medical alternatives were discussed for 2 of 3 individuals (Individuals #1 and #2) whose medical records were reviewed. This resulted in the facility's inability to identify individuals' decreased bone density status and had the potential to place individuals at an increased risk of bone fracture, without additional intervention or active treatment modifications. The findings include: 1. An article, published by the National Institute of Health in March 2010, stated cerebral palsy was associated with metabolic bone disease and a high risk for fractures. The article recommended assessment of bone mineral density every 1-2 years after age 6 for individuals diagnosed with cerebral palsy. A second article, published by the American	W 331	W331 Please refer to W124	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - STEPHANIE			STREET ADDRESS, CITY, STATE, ZIP CODE 615 NORTH STEPHANIE STREET POST FALLS, ID 83854	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 331	<p>Continued From page 3</p> <p>Epilepsy Society in March 2009, stated AED therapy was associated with metabolic bone disease and a high risk for fractures, with a reduction in bone mineral density reported in 20% - 75% of individuals taking AEDs. The article further recommended assessment of bone mineral density 3-5 years after initiation of AED therapy.</p> <p>Individuals #1 and #2 did not receive recommended bone density studies as follows:</p> <p>a. Individual #1's IPP, dated 1/13/16, documented a 42 year old male whose diagnoses included profound intellectual disability, cerebral palsy, and seizure disorder.</p> <p>Review of Individual #1's medical record showed he was receiving Depakote Sprinkles (an AED) 250 mg. twice a day.</p> <p>His record also contained a document from a local medical center, dated 5/16/12, which documented they were unable to complete a DEXA scan "... due to pt [patient] disabilities and surgeries."</p> <p>His record contained an Immunization/Screening Test form which documented a DEXA scan was not needed due to hardware per [physician's name].</p> <p>During an interview on 9/22/16 from 11:05 a.m. - 12:10 p.m., the LPN stated options, such as a portable forearm bone density screening, had not been considered or discussed with the physician for Individual #1.</p> <p>b. Individual #2's IPP, dated 7/28/16, documented</p>	W 331		

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W 331	<p>Continued From page 4</p> <p>a 29 year old male whose diagnoses included profound intellectual disability, cerebral palsy, and seizure disorder.</p> <p>Review of Individual #2's medical record showed he was receiving Lamictal (an AED) 100 mg. twice a day.</p> <p>His record contained a letter from a local health care provider, dated 5/16/12, which documented a DEXA scan was attempted, but could not be completed. It further documented no further DEXA scans should be ordered in the future due to "hardware."</p> <p>During an interview on 9/22/16 from 11:05 a.m. - 12:10 p.m., the LPN stated options to a DEXA scan, such as a portable forearm bone density screening, had not been considered or discussed with the physician for Individual #2.</p> <p>The facility failed to ensure alternative medical screenings were discussed for Individuals #1 and #2.</p>	W 331	<p>W382 Corrective Action: It is the Policy and Procedure for the facility to ensure that all medications and biologicals are maintained under lock and key. Additional training has been provided to staff to ensure they are familiar with and able to implement the facility's policy and procedures. The Home Supervisor and medical staff will routinely check all cabinets that are supposed to be locked, on a random basis during the day and throughout each week to ensure that this occurs.</p> <p>Other residents affected: all residents in the home.</p>	
W 382	<p>483.460(I)(2) DRUG STORAGE AND RECORDKEEPING</p> <p>The facility must keep all drugs and biologicals locked except when being prepared for administration.</p> <p>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 6 of 6 individuals (Individuals #1 - #6) residing at the</p>	W 382	<p>Systemic changes: see corrective action Monitor: The Program Director and Facility Nurse will train the Home Supervisors and Medical staff to follow this policy and complete the routine checks. The Program Director and facility nurse will check cabinets when they are present in the homes for added quality assurance checks.</p> <p>By whom : Program Director, Facility Nurse, Home Supervisors</p> <p>Completion Date: Nov. 1, 2016</p>	

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

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NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - STEPHANIE			STREET ADDRESS, CITY, STATE, ZIP CODE 615 NORTH STEPHANIE STREET POST FALLS, ID 83854		
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W 382	<p>Continued From page 5 facility. This resulted in drugs being left unsecured and had the potential for unauthorized access. The findings include:</p> <p>1. An observation was conducted at the facility on 9/19/16 from 4:55 - 5:50 p.m. During that time, a cabinet in the laundry room was noted to be unlocked. The cabinet contained various drugs used for routine standing orders, such as Ibuprofen and acetaminophen (analgesic drugs) and Tums (an antacid).</p> <p>The Home Supervisor, who was present during the observation, stated the medication cabinet should have been locked.</p> <p>The facility failed to ensure all drugs were maintained under locked conditions.</p>	W 382			

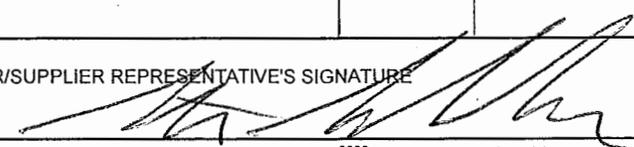
Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/22/2016
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M 000	16.03.11 Initial Comments The following deficiencies were cited during the state licensure survey conducted from 9/19/16 to 9/22/16. The survey was conducted by: Jim Troutfetter, QIDP, Team Leader	M 000		
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 W124.	MM134	MM 134 Please refer to W124	
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 W331 and W382.	MM166	MM 166 Please refer to W382 and W124	

RECEIVED
OCT 11 2016
FACILITY STANDARDS

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

 ADMIN: 10/6/16