



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1886

February 21, 2014

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

RE: Seven Oaks Community Homes - Larri Lee, Provider #13G077

Dear Mr. Silberberger:

This is to advise you of the findings of the Medicaid/Licensure survey of Seven Oaks Community Homes - Larri Lee, which was conducted on February 14, 2014.

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; and,
5. Include dates when corrective action 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

Steve Silberberger, Administrator
February 21, 2014
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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 **March 5, 2014**, 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:

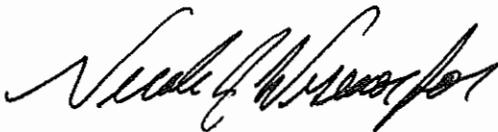
www.icfmr.dhw.idaho.gov

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 March 5, 2014. If a request for informal dispute resolution is received after March 5, 2014, 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.

Sincerely,



MONICA NIELSEN
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MN/pmt
Enclosures

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

RECEIVED

MAR 17 2014

PRINTED: 02/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/14/2014
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NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - LARRI LEE	STREET ADDRESS, CITY, STATE, ZIP CODE 583 NORTH LARRI LEE 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 deficiencies were cited during the recertification survey conducted from 2/11/14 to 2/14/14. The survey was conducted by: Monica Nielsen, QIDP, Team Leader Jim Troutfetter, QIDP Common abbreviations used in this report are: IPP - Individual Program Plan QIDP - Qualified Intellectual Disabilities Professional	W 000		
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 an individual's IPP that was directed specifically towards the reduction of and eventual elimination of the behaviors for which the drug was employed for 1 of 3 individuals (Individual #1) whose behavior modifying drugs were reviewed. This resulted in an individual receiving a behavior modifying drug without a plan that identified the drug's usage and how it may change in relation to progress or regression. The findings include:	W 312	RECEIVED MAR 17 2014 FACILITY STANDARDS It is the Facility's intent to insure that all medications used by individuals to assist them to manage inappropriate behavior are incorporated into their plans and the reduction of these medications is addressed and planned for. When a new medication is prescribed for and individual the Facility typically completes an addendum to the individual's service plan indicating how that medication will be monitored and reduced and/or ultimately eliminated. In order to insure that this component is not inadvertently overlooked the Facility will change it's procedures so that this component is prepared in conjunction with the report to the Human Rights Committee that is submitted for their approval prior to the implementation of the use of the medication. This will insure that the status of such an addendum is reviewed and that it is completed as appropriate. By Whom: Program Director and HRC Completion Date: February 28, 2014	

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>David Pickett</i>	TITLE Program Director	(X6) DATE 3-17-14
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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.

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

PRINTED: 02/20/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/14/2014
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - LARRI LEE			STREET ADDRESS, CITY, STATE, ZIP CODE 583 NORTH LARRI LEE 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 1</p> <p>1. Individual #1's IPP, dated 3/12/13, documented a 38 year old male diagnosed with severe mental retardation and behavior disorder.</p> <p>Individual #1's Physician's Order, dated 12/2013, stated he received Clonidine (an antihypertensive drug) 0.2 mg twice a day. His record included a Written Informed Consent for Clonidine, dated 6/4/13, which stated the drug was for aggression and self injurious behavior.</p> <p>However, a plan related to the use of Clonidine could not be found. When asked, the QIDP stated on 2/13/14 at 1:38 p.m., there was no plan related to Clonidine and it was an oversight.</p> <p>The facility failed to ensure Individual #1's Clonidine was incorporated into a plan.</p>	W 312			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G077	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/14/2014
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NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - LARRI LI	STREET ADDRESS, CITY, STATE, ZIP CODE 583 NORTH LARRI LEE POST FALLS, ID 83854
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M 000	<p>16.03.11 Initial Comments</p> <p>The following deficiencies were cited during the licensure survey conducted from 2/11/14 to 2/14/14.</p> <p>The survey was conducted by: Monica Nielsen, QIDP, Team Leader Jim Troutfetter, QIDP</p>	M 000		
MM197	<p>16.03.11.075.10(d) Written Plans</p> <p>Is described in written plans that are kept on file in the facility; and</p> <p>This Rule is not met as evidenced by: Refer to W312.</p>	MM197	<p>MM197</p> <p>Please refer to W312</p>	

Bureau of Facility Standards

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

TITLE

(X6) DATE

Handwritten Signature

Program Director

3-17-14