



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

IDAHO DEPARTMENT OF
HEALTH & WELFARE

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

April 24, 2014

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

RE: Seven Oaks Community Homes - Cleveland, Provider #13G049

Dear Mr. Silberberger:

This is to advise you of the findings of the Medicaid/Licensure Fire Life Safety Survey, which was concluded at Seven Oaks Community Homes - Cleveland, on April 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

Steve Silberberger, Administrator
April 24, 2014
Page 2 of 2

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 **May 7, 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 May 7, 2014. If a request for informal dispute resolution is received after May 7, 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 our staff during our visit. If you have any questions, please call our office at (208) 334-6626.

Sincerely,



MARK P. GRIMES
Supervisor
Fire Life Safety & Construction Program

MPG/lj

Enclosure

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/23/21
FORM APPROV
OMB NO. 0938-03

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING #3 B. WING _____	(X3) DATE SURVEY COMPLETED 04/14/2014
--	--	---	--

NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND	STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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
--------------------	--	---------------	---	----------------------

K 000	INITIAL COMMENTS The facility is a single story residential type building with Type V (000) construction. It was built in May of 2004. It is fully sprinklered with quick response heads. It has a complete fire alarm/smoke detection system. Currently it is licensed for five ICF/ID beds. The following deficiencies were cited at the above facility during the annual Fire/Life Safety survey conducted on April 14, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Chapter 32, New Residential Board and Care Occupancies, and in accordance with 42 CFR, 483.470 (i). The survey was conducted by: Sam Burbank Health Facility Surveyor Dan Holbrook Health Facility Surveyor Mark P Grimes Health Facility Surveyor Supervisor	K 000		
K0152	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD The facility holds evacuation drills at least quarterly for each shift of personnel and under varied conditions to ensure that all personnel on all shifts are trained to perform assigned tasks; and ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures. The facility must - (i) Actually evacuate clients during at least one drill each year on each shift; (ii) Make special provisions for the evacuation of clients with physical disabilities; (iii) File a report and evaluation on each drill;	K0152	RECEIVED MAY 14 2014 FACILITY STANDARDS The facility has implemented a new fire drill schedule to include one fire drill on a weekend or a holiday each quarter. To assure the drills are run as scheduled, I have requested that managers turn in their fire drills for the month no later than the 20 th to the Office Manager. The Office Manager will review the drills and check them off a quarterly log. When problems are to the month end. This should help alleviate any future problems, and it will be in effect, May 1 st 2014. Completion by 4/29/14 Whom: Administrator	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
		4/29/14

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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 following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued am participation.

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/23/14
FORM APPROV
OMB NO. 0938-03

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 B. WING _____	(X3) DATE SURVEY COMPLETED 04/14/2014
--	--	---	--

NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND	STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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
--------------------	--	---------------	---	----------------------

K0152

Continued From page 1
(iv) Investigate all problems with evacuation drills, including accidents and take corrective action: and
(v) During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code.

Facilities meet the requirements of paragraphs (1) and (2) of this section for any live-in and relief staff that they utilize.

K0152

The facility at 3732 Cleveland Court was found to be out of compliance for missing a documented fire drill for the weekend shift of the 3rd quarter 2013. Although the proper number of drills were run in the 3rd quarter, they were not completed on a weekend or holiday.

This STANDARD is not met as evidenced by:
Based on interview and record review, the facility failed to provide documented fire drills for each shift in each quarter for the last twelve months. Failure to perform necessary fire drills in each quarter as required has the potential to adversely affect the ability of clients, staff and visitors to evacuate safely in the event of a fire. This deficient practice affected all clients, staff and visitors. The facility is licensed for 5 ICF/ID beds and had a census of 4 on the date of the survey

Findings include:

During record review of the facility's fire drill reports for the 12 month period prior to the survey conducted on 4/14/2014, the facility was unable to provide a documented fire drill for the weekend shift of the 3rd quarter of 2013. During the exit conference conducted with the Administrator on 4/14/2014 at approximately 4:40 PM, the Administrator acknowledged that the facility did

[Signature] 4/15/14

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

PRINTED: 04/23/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 B. WING _____	(X3) DATE SURVEY COMPLETED 04/14/2014
--	--	---	--

NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND	STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND 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
K0152	<p>Continued From page 2</p> <p>not have documentation of this drill being performed.</p> <p>Actual Standard: 483.470(j)(1)(i)</p> <p>The facility holds evacuation drills at least quarterly for each shift of personnel and under varied conditions to ensure that all personnel on all shifts are trained to perform assigned tasks; and ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures.</p> <p>The facility must -</p> <ul style="list-style-type: none"> (i) Actually evacuate clients during at least one drill each year on each shift; (ii) Make special provisions for the evacuation of clients with physical disabilities; (iii) File a report and evaluation on each drill; (iv) Investigate all problems with evacuation drills, including accidents and take corrective action; and (v) During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code. <p>Facilities meet the requirements of paragraphs (1) and (2) of this section for any five-in and relief staff that they utilize.</p>	K0152		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 03 B. WING: _____	(X3) DATE SURVEY COMPLETED 04/14/2014
--	--	---	--

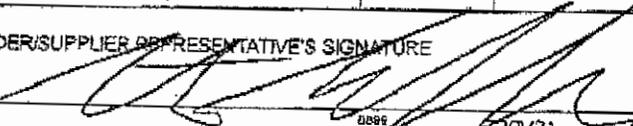
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVEL	STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND STREET POST FALLS, ID 83854
---	--

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

M 000	<p>16.03.11 Initial Comments</p> <p>The facility is a single story residential type building with Type V (000) construction. It was built in May of 2004. It is fully sprinklered with quick response heads. It has a complete fire alarm/smoke detection system. Currently it is licensed for five ICF/ID beds.</p> <p>The following deficiencies were cited at the above facility during the annual Fire/Life Safety survey conducted on April 14, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Chapter 32, New Residential Board and Care Occupancies, and in accordance with 42 CFR, 483.470 (i) and IDAPA 16.03.11 Rules Governing Intermediate Care Facilities for Individuals with Intellectual Disabilities.</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Dan Holbrook Health Facility Surveyor Mark P Grimes Health Facility Surveyor Supervisor</p>	M 000		
-------	---	-------	--	--

RECEIVED
MAY 14 2014
FACILITY STANDARDS

MM344	<p>16.03.11.110.06(e) Automatic Sprinkler Systems</p> <p>Automatic sprinkler systems, if installed, must be serviced at least annually by an authorized servicing agency. Servicing must be in accordance with the applicable NFPA Standard 13a (1978 edition), "Care and Maintenance of Sprinkler Systems."</p> <p>This Rule is not met as evidenced by: Based on observation and interview the facility failed to maintain the sprinkler head trim coverings as required. Failure to maintain the trim covering for sprinkler heads could allow the passage of heat, smoke and toxic gases to unprotected areas. This deficient practice</p>	MM344		
-------	--	-------	--	--

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ADMIN	(X5) DATE 4/23/14
---	--------------------	----------------------

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 03 B. WING: _____	(X3) DATE SURVEY COMPLETED 04/14/2014
--	--	---	--

NAME OF PROVIDER OR SUPPLIER
SEVEN OAKS COMMUNITY HOMES - CLEVEL

STREET ADDRESS, CITY, STATE, ZIP CODE
**3732 NORTH CLEVELAND 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) COMPLETE DATE
MM344	<p>Continued From page 1</p> <p>affected all clients, staff and visitors on the date of survey. The facility was licensed for 5 beds and had a census of 4 on the day of survey.</p> <p>Findings include:</p> <p>During the tour of the facility on April 14, 2014 between the hours of 8:30 AM to 2:30 PM it was observed that the trim ring which covers the sprinkler head opening in the ceiling of the kitchen pantry was missing. This observation was acknowledged by the administrator during the tour.</p> <p>Actual NFPA Standard: NFPA 13.12-1</p> <p>12-1* General. A sprinkler system installed in accordance with this standard shall be properly inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, to provide at least the same level of performance and protection as designed.</p>	MM344	<p>MM344</p> <p>The facility will assure the sprinkler system installed is properly inspected, tested, and maintained in accordance with NFPA 25 Standard for inspection, testing and maintenance of water based fire protection systems. The facility has implemented a monthly fire inspection to be completed by the facilities Administrator or the facility maintenance person. Also a licensed plumber or fire protection service company will inspect the system on an annual basis and as needed for any problems that may arise. The inspection will include observing each fire sprinkler head to assure they are properly installed and not missing caps, rings, or receding into the attic. Completion Date 4/29/14 By Whom: Administrator</p> <p><i>[Signature]</i> 4/25/14</p>	