



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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April 24, 2014

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 Fire Life Safety Survey, which was concluded at Seven Oaks Community Homes - Stephanie, on April 14, 2014.

Enclosed is your copy of a Statement of Deficiencies/Plan of Correction, form CMS-2567, which states that no Medicaid deficiencies were noted at the time of the survey. Also, enclosed is a similar form stating that no State licensure deficiencies were noted at the time of the survey.

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  
Facility Fire Safety and Construction Program

MPG/lj

Enclosure

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:  <b>13G054</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>03 , 02</b> B. WING _____		(X3) DATE SURVEY COMPLETED  <b>04/14/2014</b>
NAME OF PROVIDER OR SUPPLIER <b>SEVEN OAKS COMMUNITY HOMES - STEPHA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>615 NORTH STEPHANIE STREET POST FALLS, ID 83854</b>		
(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	<p><b>INITIAL COMMENTS</b></p> <p>The facility is a single story residential building with Type V (000) construction. It was built in June of 2007. It is fully sprinklered with quick response heads. It has complete fire alarm/smoke detection system. Currently it is licensed for six ICF/ID beds.</p> <p>The facility was found to be in substantial compliance with applicable life safety requirements during the annual Life Safety survey conducted on April 14, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 edition, Chapter 32, New Residential Board &amp; Care Occupancies, Impractical Evacuation Capability in accordance with 42 CFR 483.470 (j).</p> <p>The Survey was conducted by:</p> <p>Dan Holbrook Fire Health Surveyor Sam Burbank Fire Health Surveyor Mark Grimes Supervisor Facility Fire Safety and Construction</p>	K 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G054</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>03 , 02</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/14/2014</b>
NAME OF PROVIDER OR SUPPLIER <b>SEVEN OAKS COMMUNITY HOMES - STEPHANIE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>615 NORTH STEPHANIE STREET POST FALLS, ID 83854</b>		
(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 building with Type V (000) construction. It was built in June of 2007. It is fully sprinklered with quick response heads. It has complete fire alarm/smoke detection system. Currently it is licensed for six ICF/ID beds.</p> <p>The facility was found to be in substantial compliance with applicable life safety requirements during the annual Life Safety survey conducted on April 14, 2014. The facility was surveyed under the IDAPA 16.03.11 Rules Governing Intermediate Care Facilities for People with Intellectual Disabilities.</p> <p>The Survey was conducted by:</p> <p>Dan Holbrook Fire Health Surveyor Sam Burbank Fire Health Surveyor Mark Grimes Supervisor Facility Fire Safety and Construction</p>	M 000		

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

TITLE

(X6) DATE