



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 208-364-1888

June 10, 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 survey of Seven Oaks Community Homes - Stephanie, which was conducted on June 5, 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;
5. The plan must include the title of the person responsible for implementing the acceptable plan of correction; and

Steve Silberberger, Administrator  
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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 **June 22, 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](http://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 June 22, 2014. If a request for informal dispute resolution is received after June 22, 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,



MICHAEL CASE  
Health Facility Surveyor  
Non-Long Term Care



NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

MC/pmt  
Enclosures

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

PRINTED: 06/09/2014  
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  06/05/2014
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 000	INITIAL COMMENTS  The following deficiencies were cited during the recertification survey conducted from 6/2/14 - 6/5/14.  The survey was conducted by: Michael Case, LSW, QIDP, Team Leader Karen Marshall, MS, RD, LD  Common abbreviations used in this report are:  IDT - Interdisciplinary Team IPP - Individualized Program Plan QIDP - Qualified Intellectual Disabilities Professional	W 000			
W 259	483.440(f)(2) PROGRAM MONITORING & CHANGE  At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure assessments were accurate and comprehensive for 1 of 3 individuals (Individual #1) whose assessments and IPPs were reviewed. This resulted in a lack of assessment information on which to base program decisions. The findings include:  1. Individual #1's 1/28/14 IPP stated he was a 39 year old male whose diagnoses included severe mental retardation, cerebral palsy, and quadriplegia. Individual #1's IPP included an objective to communicate with an iPad.	W 259	W 259  It is the facilities intent to insure that accurate assessment information in all areas including speech and language development is available and included in each person's record. Each person's record has been reviewed to insure that all assessment information is current and accurate and a new speech assessment has been completed for the individual identified. All evaluations will be reviewed on at least an annual basis and updated as appropriate as part of each person's annual staffing.  By Whom: QIDP, Home Supervisor Completion Date: June 30, 2014	RECEIVED JUL - 9 2014 FACILITY STANDARDS	

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

*Claude Pickett*

TITLE

*Program Director*

(X8) DATE

7-9-14

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.

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W 259	Continued From page 1  Observations were conducted at the day program on 6/2/14 from 11:20 a.m. - 12:10 p.m., at the facility on 6/2/14 from 4:23 - 5:10 p.m., and on 6/3/14 from 6:55 - 8:05 a.m. and 6:10 - 6:55 p.m. During those times, Individual #1 was noted to be offered the use of an iPad for communication purposes. Individual #1 could express wants and needs by touching icons on the iPad. No other communication device was observed to be present in the facility.  However, Individual #1's Communication Evaluation Report, dated 3/10/12, stated Individual #1 was non-verbal and utilized a "wrist talker" communication device to express his wants and needs. The Report did not contain information related to Individual #1's iPad, his abilities to access and manipulate the device, or what needs he had in relation to his ability to communicate with the device.  During an interview on 6/5/14 from 9:35 a.m. - 12:00 p.m., the Home Supervisor stated Individual #1's wrist talker was no longer being used as replacement parts for the device could not be obtained. The QIDP, who was present during the interview, stated the IDT believed the iPad would be more functional for Individual #1, but stated they had not assessed Individual #1's abilities or needs regarding the use of the iPad. The QIDP stated the communication assessment needed to be updated.  The facility failed to ensure Individual #1's record included updated and accurate information regarding his communication abilities and needs.	W 259			
W 440	483.470(i)(1) EVACUATION DRILLS	W 440			

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W 440	Continued From page 2  The facility must hold evacuation drills at least quarterly for each shift of personnel.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure evacuation drills were conducted quarterly for each shift of personnel for 6 of 6 individuals (Individuals #1 - #6) residing at the facility. This resulted in the potential for the facility and staff not being able to determine individuals' responses or identify problem areas. The findings include:  1. The facility's evacuation drills were reviewed and did not include documentation that an evacuation drill had been completed for the day shift (6:00 a.m. - 2:00 p.m.) of the first quarter (January - March) of 2014.  During an interview on 6/5/14 from 9:35 a.m. - 12:00 p.m., the QIDP and Home Supervisor both stated the drill had not been completed due to an oversight.  The facility failed to ensure evacuation drills were completed each quarter for each shift of staff.	W 440	<b>W440</b>  It is the facility's intent to hold evacuation drills at least a quarterly for each shift of personnel. The Office Manager routinely receives fire drills and files these drills. She will record the drills and notify both the home supervisor and the Program Director in the event fire drills are not completed. In addition fire drills are included on the home supervisors monthly activity list and a copy of each completed fire drill will be submitted to the program director to insure that fire drills are completed.  By Whom: Program Director, Home Supervisor, Office Manager Completion Date: June 30, 2014	

Bureau of Facility Standards

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M 000	16.03.11 Initial Comments  The following deficiencies were cited during the licensure survey conducted from 6/2/14 - 6/5/14.  The survey was conducted by: Michael Case, LSW, QIDP, Team Leader Karen Marshall, MS, RD, LD	M 000		
MM724	16.03.11.270.01(a) Assesments  As a basis for individual program planning and program implementation, assessments must be provided at entry and at least annually thereafter by an interdisciplinary team composed of members drawn from or representing such professions, disciplines or services areas as are relevant to each particular case. This Rule is not met as evidenced by: Refer to W259.	MM724	MM724  Please refer to W259	

**RECEIVED**  
JUL - 9 2014  
FACILITY STANDARDS

Bureau of Facility Standards  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Claude Pater*

TITLE

*Program Director*

(X6) DATE

7-9-14