



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

December 23, 2013

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

RE: Seven Oaks Community Homes - Knapp West, Provider #13G068

Dear Mr. Silberberger:

This is to advise you of the findings of the Medicaid/Licensure survey of Seven Oaks Community Homes - Knapp West, which was conducted on December 19, 2013.

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  
December 23, 2013  
Page 2 of 2

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 **January 6, 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:

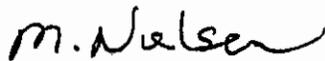
[www.icfmr.dhw.idaho.gov](http://www.icfmr.dhw.idaho.gov)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  12/19/2013
NAME OF PROVIDER OR SUPPLIER  SEVEN OAKS COMMUNITY HOMES - KNAPP WEST			STREET ADDRESS, CITY, STATE, ZIP CODE 2898 KNAPP CIRCLE 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 annual recertification survey conducted from 12/16/13 - 12/19/13.  The survey was conducted by: Monica Nielsen, QIDP, Team Leader  Common abbreviations used in this report are:  CNA - Certified Nurse Assistant IPP - Individual Program Plan QIDP - Qualified Intellectual Disability Professional	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 parents/guardians on which to base consent decisions for 1 of 1 individual (Individuals #1) reviewed, who was in need of gynecological services. This resulted in a lack of information being provided to the individual's guardian regarding pap smears. The findings include:  1. Individual #1's IPP, dated 1/29/13, documented	W 124	RECEIVED  JAN - 9 2014  FACILITY STANDARDS  W124  It is the facility's intent to insure that all clients, parents, and guardians are informed of available procedures and their benefits and risks and to have documentation regarding informed consent regarding a particular procedure. In this particular situation the facility did not recognize that documenting the guardians consent to deferral of a procedure the person's physician deemed unnecessary was appropriate. The facility will review all medical treatment being offered or deferred for individuals in the home and obtain informed consent from guardians as appropriate.  By Whom: Administrator, Nursing staff Completion Date: January 31, 2014	

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

TITLE

(X6) DATE

*Sharon Pickett*

*Program Director*

*1-9-14*

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 124	<p>Continued From page 1</p> <p>a 29 year old female diagnosed with Angelman syndrome, profound mental retardation, and seizure disorder.</p> <p>Individual #1's record included a letter from her physician, dated 1/26/09, which stated Individual #1 would not allow a pelvic exam or pap smear. The letter stated "...a Pap smear at this time is not necessary. She has never been sexually active and has a very small introitus, making an exam very difficult. We have tried to do a Pap smear in the past and it was not possible, unless we considered general anesthetic..."</p> <p>However, Individual #1's record did not contain a consent with information related to the intended outcome or benefits of a pap smear, steps to be taken to minimize the risks associated with the procedure, ramifications if the decision was not to participate, alternatives to the proposed procedure, and that consent to participate could be withdrawn at any time without risk of punitive action.</p> <p>When asked on 12/18/13 at 11:50 a.m., the CNA stated there was no written informed consent related to pap smears for Individual #1.</p> <p>The facility failed to ensure informed consent related to pap smears was obtained for Individual #1.</p>	W 124			
W 259	<p>483.440(f)(2) PROGRAM MONITORING &amp; CHANGE</p> <p>At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed.</p>	W 259	<p><b>W259</b></p> <p>The facility routinely obtains baselines, documents episodes of behaviors, completes annual comprehensive assessments and documents illnesses, injuries, and seizures for individuals. In this situation after consulting with the survey team the use of Melatonin was considered a medical treatment being used to</p>		

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

PRINTED: 12/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

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W 259	Continued From page 2  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure comprehensive assessment information was garnered for 1 of 2 individuals (Individual #1) whose records were reviewed. This resulted in a lack of information on which to base medical care intervention decisions. The findings include:  1. Individual #1's IPP, dated 1/29/13, documented a 29 year old female diagnosed with Angelman syndrome, profound mental retardation, and seizure disorder.  Her record included physician's orders, dated 12/1/13, which documented she received Melatonin 3 mg each evening. A 1/24/13 Neurology Clinic report documented the Melatonin was being given to assist Individual #1 with her sleep. The report stated "...She appears to get adequate number of sleep hours. I reviewed the literature, it is common for individuals with Angelman syndrome to have some amount of sleep disturbance, and melatonin [sic] seems to be frequently employed for its use..." The Assessment and Plan section of the report stated "I would like [Individual #1] also to try melatonin [sic] 3 mg at bedtime to see if sleep improves and also results in better seizure control..."  However, information related to Individual #1's sleep could not be found in her record. A sleep study was not present and no assessment information related to her sleeping habits (quality or quantity) or other factors which impacted her sleep (e.g. environmental factors, seizure activities, medication changes, etc.) could not be	W 259	W259 Continued from page 2  facilitate seizure control. As such the focus was on seizure activity which was consistently documented. The facility does agree that additional assessment could provide information related to her sleep and result in a change in treatment being provided. The facility will consult with the Neurologist regarding the possibility of formal sleep study and begin assessment per his recommendation. In the future in similar situations the facility will take a broader approach to obtaining additional behavioral information for consultants to review and consider.  By Whom: Nursing Staff, QIDP Completion Date: January 31, 2014		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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W 259	<p>Continued From page 3 found.</p> <p>Further, Individual #1's record did not include data documenting her sleep prior to or after the initiation of Melatonin. Without such data, it would not be possible for the facility to analyze the effectiveness of the Melatonin or correlate its use with impacts on her seizure activity.</p> <p>When asked on 12/18/13 at 2:30 p.m., the QIDP stated there was no sleep study, assessment, or tracking of Individual #1's sleep.</p> <p>The facility failed to ensure comprehensive assessment information was garnered related to Individual #1's sleep and its impact on her seizure activity.</p>	W 259			

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER  
**SEVEN OAKS COMMUNITY HOMES - KNAPP V**

STREET ADDRESS, CITY, STATE, ZIP CODE  
**2898 KNAPP CIRCLE  
POST FALLS, ID 83854**

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M 000	16.03.11 Initial Comments  The following deficiencies were cited during the licensure survey conducted from 12/16/13 - 12/19/13.  The survey was conducted by: Monica Nielsen, QIDP, Team Leader	M 000		
MM164	16.03.11.075.04 Development of Plan of Care  To Participate in the Development of Plan of Care. The resident must have the opportunity to participate in his plan of care. Residents must be advised of alternative courses or care and treatment and their consequences when such alternatives are available. The resident's preference about alternatives must be elicited and considered in deciding on the plan of care. A resident may request, and must be entitled to, representation and assistance by any consenting person of his choice in the planning of his care and treatment. This Rule is not met as evidenced by: Refer to W124.	MM164	MM164 Please Refer to W124	
MM724	16.03.11.270.01(a) Assessments  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  
JAN - 9 2014  
FACILITY STANDARDS

Bureau of Facility Standards  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Monica Nielsen* TITLE *Program Director* (X6) DATE *1-9-14*