



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 Ecker Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

December 3, 2014

Richard M. Ord, Administrator  
Bennett Hills Center  
1220 Montana Street  
Gooding, ID 83330-1856

Provider #: 135134

Dear Mr. Ord:

On **November 21, 2014**, a Recertification and State Licensure survey was conducted at Bennett Hills Center by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. Your facility was found to be in compliance with state licensure and federal health care requirements regulations during this survey.

Enclosed is a Statement of Deficiencies/Plan of Correction, CMS Form 2567, listing no Medicare/Medicaid deficiencies and a similar Statement of Deficiencies/Plan of Correction, State Form, listing no licensure health deficiencies. These forms are for your records only and do not need to be returned.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Lorene Kayser, L.S.W., Q.I.D.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626, Option 2.

Sincerely,

LORENE KAYSER, L.S.W., Q.I.D.P., Supervisor  
Long Term Care

LKK/dmj  
Enclosures

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

PRINTED: 12/03/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135134</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/21/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>BENNETT HILLS CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1220 MONTANA STREET GOODING, ID 83330</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	
F 000	<p><b>INITIAL COMMENTS</b></p> <p>Bennett Hills Center is in substantial compliance with 42 CFR Part 483 Requirements for Long Term Care Facilities.</p> <p>The surveyors conducting the survey were: Amy Barkley, RN, BSN, Team Coordinator Judy Atkinson, RN</p> <p>The survey team entered the facility on November 17, 2014 and exited on November 21, 2014</p>	F 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.

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001235</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/21/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BENNETT HILLS CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1220 MONTANA STREET GOODING, ID 83330</b>
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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>Bennett Hills Center is in compliance for the annual state survey.</p> <p>The surveyors conducting the survey were:</p> <p>Amy Barkley, RN, BSN, Team Coordinator Judy Atkinson, RN</p>	C 000		

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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