



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSELL S. BARRON – Director

TAMARA PRISOCK – ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
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

November 16, 2017

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

Provider #: 135134

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Ord:

On **November 7, 2017**, a Facility Fire Safety and Construction 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. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must

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be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **November 29, 2017**. Failure to submit an acceptable PoC by **November 29, 2017**, may result in the imposition of civil monetary penalties by **December 19, 2017**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;

- 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,
- Include dates when corrective action will be completed.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567. If a State Form was issued as well, it should also be signed, dated and returned.

All references to federal regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Remedies may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **December 12, 2017**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **December 12, 2017**. A change in the seriousness of the deficiencies on **December 12, 2017**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **December 12, 2017**, includes the following:

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Denial of payment for new admissions effective **February 7, 2018**.
42 CFR §488.417(a)

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **May 7, 2018**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **November 7, 2017**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, 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 Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

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Go to the middle of the page to Information Letters section and click on State and select the following:

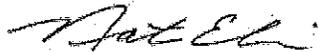
BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **November 29, 2017**. If your request for informal dispute resolution is received after **November 29, 2017**, 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 the survey. If you have any questions, please contact us at (208) 334-6626, option 3.

Sincerely,



Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135134	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - HELPING HANDS OF GOODING B. WING _____	(X3) DATE SURVEY COMPLETED 11/07/2017
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NAME OF PROVIDER OR SUPPLIER BENNETT HILLS CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1220 MONTANA STREET GOODING, ID 83330
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(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
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K 000 INITIAL COMMENTS

The facility is a single story, Type V(111) structure constructed in August of 1971. It is fully sprinklered with a complete fire alarm/smoke detection system in hallways and open spaces. Currently the facility is licensed for 80 SNF/NF beds.

The following deficiencies were cited during the annual fire/life safety survey conducted on November 7, 2017. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.

The survey was conducted by:

Linda Chaney
Health Facility Surveyor
Facility Fire Safety and Construction

K 211 NFPA 101 Means of Egress - General
SS=D

Means of Egress - General
Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11.

18.2.1, 19.2.1, 7.1.10.1
This STANDARD is not met as evidenced by:
Based on observation and operational testing, the facility failed to ensure means of egress were maintained free of obstructions to immediate use in the event of an emergency. Failure to provide means of egress available for immediate use has the potential to hinder egress of residents during an emergency. This deficient practice affected

K 000

F000
The Bennett Hills Center provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The Plan of Correction is prepared and executed solely because it is required by federal and state law.

RECEIVED

NOV 28 2017

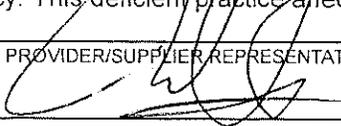
K 211 - D

FACILITY STANDARDS

12/08/17

- 1) The 3 doors that exit out of the kitchen with the non-single operational lock on the egress side of the door were replaced; this was completed as of 11/30/17.
- 2) A review of the whole facility was completed by the maintenance manager with no other doors found with non-single operational lock on the egress side in the building as of 11/08/17.
- 3) Weekly documentation for non-single operational lock on egress side doors will be completed by the maintenance manager for 4 weeks.
- 4) The maintenance manager has received education from the administrator regarding the importance of the NFPA 101 chapter 7 standard; this was completed by 11/30/17.
- 5) The 4 weekly audits results performed by the maintenance manager will be reviewed by the quality committee in the December and January QAPI meetings. The QAPI meetings will be held on 12/12/17 and 01/09/18. Further action by the QAPI team will be taken if necessary at that time.

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



TITLE

CEO

(X6) DATE

11/28/17

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.

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

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OMB NO. 0938-0391

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K 211 Continued From page 1
staff and visitors on the date of the survey. The facility is currently licensed for 80 SNF/NF beds and had a census of 32 on the day of the survey.

Findings include:

During the facility tour conducted on November 7, 2017 from approximately 11:30 AM to 2:00 PM, observation and operational testing of the doors from the kitchen revealed all three (3) exit doors were equipped with a non-single operational lock on the egress side.

Actual NFPA standard:

NFPA 101
Chapter 7
7.2 Means of Egress Components.
7.2.1.5 Locks, Latches, and Alarm Devices.
7.2.1.5.1 Door leaves shall be arranged to be opened readily from the egress side whenever the building is occupied.
7.2.1.5.10.2 The releasing mechanism shall open the door leaf with not more than one releasing operation, unless otherwise specified in 7.2.1.5.10.3, 7.2.1.5.10.4, or 7.2.1.5.10.6.

K 353 NFPA 101 Sprinkler System - Maintenance and SS=E Testing

Sprinkler System - Maintenance and Testing
Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.

K 211

K 353 - E

- 1) The 3 sprinklers that were found to have paint on them, along with 5 other sprinklers identified after the survey on 11/08/17; totaling 8 sprinklers were replaced with quick response sprinklers on 11/30/17.
- 2) Maintenance reviewed the whole building and found 5 other sprinklers in need of replaced totaling 8 sprinklers. This review was completed on 11/08/17.
- 3) Weekly documentation for checking all rooms for painted sprinklers by the maintenance manager for 4 weeks to assure that there is none in the building.
- 4) The maintenance manager has received education from the administrator regarding the importance of identifying and having replaced painted sprinklers in the building was completed by 12/08/17.
- 5) The 4 weekly audits results performed by the maintenance manager will be reviewed by the quality committee in the December and January QAPI meetings. The QAPI meetings will be held on 12/12/17 and 01/09/18. Further action by the QAPI team will be taken if necessary at that time.

12/08/17

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K 353	<p>Continued From page 2</p> <p>a) Date sprinkler system last checked</p> <p>b) Who provided system test</p> <p>c) Water system supply source</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure fire suppression system pendants were maintained free of obstructions such as paint or corrosion. Failure to maintain fire sprinkler pendants free of obstructions could hinder system performance during a fire event. This deficient practice affected 19 residents, staff and visitors on the date of the survey. The facility is licensed for 80 SNF/NF beds and had a census of 32 on the day of the survey.</p> <p>Findings include:</p> <p>Observation during the facility tour on November 7, 2017, from approximately 11:30 AM to 2:00 PM, revealed two (2) sprinkler heads in the storage closet in the East Hallway between resident room #23 and #24 had paint on them. There was also paint on a sprinkler head in the South East Hallway, outside of the dining room. When asked, the Maintenance Supervisor stated the facility was not aware of the painted sprinkler heads.</p> <p>Actual NFPA standard:</p> <p>NFPA 25 5.2.1 Sprinklers.</p>	K 353	

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K 521	<p>Continued From page 4</p> <p>facility is licensed for 80 SNF/NF beds with a census of 32 on the day of survey.</p> <p>Findings include:</p> <p>1.) During the review of facility inspection records on November 7, 2017, from approximately 9:30 AM to 11:30 AM, no records were available indicating inspection and testing of smoke/fire dampers. When asked, the Maintenance Supervisor stated the facility did have smoke/fire dampers, but was told by the contractor that they did not require testing. He further stated that, the facility had never inspected or tested the smoke/fire dampers.</p> <p>2.) On November 13, 2017, observation of the mechanical plans for the facility, revealed smoke/fire dampers were installed throughout the facility, at the roof top units.</p> <p>Actual NFPA standard:</p> <p>NFPA 101 19.5.2 Heating, Ventilating, and Air-Conditioning. 19.5.2.1 Heating, ventilating, and air-conditioning shall comply with the provisions of Section 9.2 and shall be installed in accordance with the manufacturer's specifications, unless otherwise modified by 19.5.2.2.</p> <p>9.2 Heating, Ventilating, and Air-Conditioning. 9.2.1 Air-Conditioning, Heating, Ventilating Ductwork, and Related Equipment. Air-conditioning, heating, ventilating ductwork, and related equipment shall be in accordance with NFPA 90 A, Standard for the Installation of Air-Conditioning and Ventilating Systems, or NFPA 90B, Standard for the Installation of Warm</p>	K 521	

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K 521	Continued From page 5 Air Heating and Air-Conditioning Systems, as applicable, unless such installations are approved existing installations, which shall be permitted to be continued in service. NFPA 90 A 5.4.8.1 Fire dampers and ceiling dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. 5.4.8.2 Smoke dampers shall be maintained in accordance with NFPA 105, Standard for Smoke Door Assemblies and Other Opening Protectives. NFPA 80 19.4.1 Each damper shall be tested and inspected 1 year after installation. 19.4.1.1 The test and inspection frequency shall then be every 4 years, except in hospitals, where the frequency shall be every 6 years. NFPA 105 6.5.2* Each damper shall be tested and inspected one year after installation. The test and inspection frequency shall then be every 4 years, except in hospitals, where the frequency shall be every 6 years.	K 521	
K 926 SS=D	NFPA 101 Gas Equipment - Qualifications and Training Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment.	K 926	

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K 926	<p>Continued From page 6</p> <p>11.5.2.1 (NFPA 99) This STANDARD is not met as evidenced by: Based on record review, and interview, the facility failed to ensure staff were properly trained on the risks associated with the handling and use of medical gases. Failure to provide an education program which includes periodic review of safety guidelines and usage requirements for medical gases and their cylinders, could result in a life threatening or catastrophic accident. This deficient practice could potentially affect 9 residents using oxygen on the date of the survey. The facility is licensed for 80 SNF/NF residents and had a census of 32 on the day of the survey.</p> <p>Findings include:</p> <p>During the review of facility training records conducted on November 7, 2017 from approximately 9:30 AM to 11:30 AM, no records were available indicating that the facility maintains an ongoing continuing education program for staff which includes periodic review of safety guidelines and usage requirements for medical gases and their cylinders. When asked, the Maintenance Supervisor stated the facility was not aware of the requirement for medical gas training.</p> <p>Actual NFPA Standard:</p> <p>NFPA 101 19.3.2.4 Medical Gas. Medical gas storage and administration areas shall be in accordance with Section 8.7 and the provisions of NFPA 99, Health Care Facilities Code, applicable to administration, maintenance, and testing. NFPA 99 11.5.2 Gases in Cylinders and Liquefied Gases in</p>	K 926 - D	<p>1) The Continued education for direct care staff which includes safety guidelines and usage requirements for medical gases and their cylinders was completed by the nurse manager/trainer or designee by 11/29/17.</p> <p>2) Documentation of the direct care staff being educated on the guidelines and usage requirements for medical gases and their cylinders was reviewed by the nurse manager/trainer or designee as of 11/30/17 for completeness. New hire employees will be educated and not allowed to fill buddies until the education is complete.</p> <p>3) Documentation of the education was reviewed for 4 weeks by nurse manager/trainer or designee. To ensure that all direct care employees have been educated.</p> <p>4) Managers and designees have received education from the administrator regarding the importance of educated on the guidelines and usage requirements for medical gases and their cylinders; this was completed by 12/08/17.</p> <p>5) The 4 weekly audits results performed by the maintenance manager will be reviewed by the quality committee in the December and January QAPI meetings. The QAPI meetings will be held on 12/12/17 and 01/09/18. Further action by the QAPI team will be taken if necessary at that time.</p> <p>12/08/17</p>

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K 927	<p>Continued From page 8</p> <p>staff and visitors on the date of the survey. The facility is licensed for 80 SNF/NF beds and had a census of 32 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on November 7, 2017 from approximately 11:30 AM to 2:00 PM, observation and operational testing of the fan for the oxygen storage/transfill area revealed the fan was not operational.</p> <p>Actual NFPA standard:</p> <p>NFPA 99</p> <p>11.5.2.3 Transfilling Liquid Oxygen. Transfilling of liquid oxygen shall comply with 11.5.2.3.1 or 11.5.2.3.2, as applicable.</p> <p>11.5.2.3.1 Transfilling to liquid oxygen base reservoir containers or to liquid oxygen portable containers over 344.74 kPa (50 psi) shall include the following:</p> <p>(1) A designated area separated from any portion of a facility wherein patients are housed, examined, or treated by a fire barrier of 1 hour fire-resistive construction.</p> <p>(2) The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring.</p> <p>(3) The area is posted with signs indicating that transfilling is occurring and that smoking in the immediate area is not permitted.</p> <p>(4) The individual transfilling the container(s) has been properly trained in the transfilling procedures.</p> <p>9.3.7.5.3.2 Mechanical exhaust shall be at a rate of 1 L/sec of airflow for each 300 L (1 cfm per 5 ft3 of fluid) designed to be stored in the space</p>	K 927		

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K 927	Continued From page 9 and not less than 24 L/sec (50 cfm) nor more than 235 L/sec (500 cfm).	K 927		