



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

COPY

December 28, 2018

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

Provider #: 135134

**RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER**

Dear Mr. Ord:

On **December 18, 2018**, a Facility Fire Safety and Construction survey was conducted at **Bennett Hills Rehabilitation And Care 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 wpattern 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 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

Richard Ord, Administrator  
December 28, 2018  
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you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must 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 **January 10, 2019**. Failure to submit an acceptable PoC by **January 10, 2019**, may result in the imposition of civil monetary penalties by **February 1, 2019**.

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 , (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 **March 18, 2019**. A change in the seriousness of the deficiencies on **February 1, 2019**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by ,

Richard Ord, Administrator  
December 28, 2018  
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includes the following:

Denial of payment for new admissions effective .  
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 , 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 **December 18, 2018**, 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>

Richard Ord, Administrator  
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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 **January 10, 2019**. If your request for informal dispute resolution is received after **January 10, 2019**, 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

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

PRINTED: 12/28/2018  
FORM APPROVED  
OMB NO. 0938-0391

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  12/18/2018
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NAME OF PROVIDER OR SUPPLIER  BENNETT HILLS REHABILITATION AND CARE 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. The Essential Electrical System is supplied by a propane powered, on-site automatic generator. Currently the facility is licensed for 80 SNF/NF beds and had a census of 30 on the date of the survey.

The following deficiency was cited during the annual fire/life safety survey conducted on December 18, 2018. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70, and 42 CFR 483.80.

The survey was conducted by:

Linda Chaney  
Health Facility Surveyor  
Facility Fire Safety and Construction

K 232 Aisle, Corridor, or Ramp Width  
SS=E

Aisle, Corridor or Ramp Width  
2012 EXISTING

The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5.

19.2.3.4, 19.2.3.5

This REQUIREMENT is not met as evidenced by:

Based on observation and interview, the facility

F000

The Bennett Hills Rehabilitation and Care 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

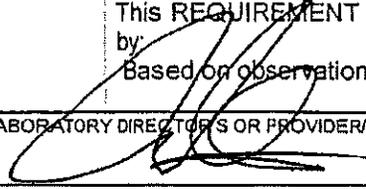
JAN 07 2018

FACILITY STANDARDS

K232 - E

2/1/19

- 1) The 3 fire extinguisher boxes that were 5 inches extended out from the wall in the 3 hallways, will be no more than 4 inches out from the wall in the hallways, completed by the Maintenance Supervisor as of 02/01/19. They will be placed at the appropriate inches from the floor per the regulation.
- 2) A review of the whole facility was completed by the Maintenance Supervisor with no other fire extinguisher boxes found to be at 5 inches extended from the wall in the building as of 12/18/18.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Rich Ong	TITLE Administrator	(X6) DATE 01/7/19
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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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NAME OF PROVIDER OR SUPPLIER  BENNETT HILLS REHABILITATION AND CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1220 MONTANA STREET GOODING, ID 83330
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K 232 Continued From page 1  
failed to maintain corridor exit access free of obstructions. Failure to maintain exit access width in the path of travel, could hinder the safe evacuation of residents during a fire or other emergency. This deficient practice affected 30 residents, staff and visitors on the date of the survey.

Findings include:  
During the facility tour on December 18, 2018, from approximately 1:30 PM to 3:30 PM, observation of the exit access corridors revealed fire extinguisher boxes projecting from the corridor wall 5 inches at a height above the hand rail and below 80". The fire extinguisher boxes were in the North, South and Southeast corridors for a total of three (3) boxes. When asked, the Maintenance Supervisor stated the facility was unaware of the requirements for non-continuous projections in the corridor.

Actual NFPA Standard:  
19.2.3.4\* Any required aisle, corridor, or ramp shall be not less than 48 in. (1220 mm) in clear width where serving as means of egress from patient sleeping rooms, unless otherwise permitted by one of the following:  
(1) Aisles, corridors, and ramps in adjunct areas not intended for the housing, treatment, or use of inpatients shall be not less than 44 in. (1120 mm) in clear and unobstructed width.  
(2) \*Where corridor width is at least 6 ft (1830 mm), non-continuous projections not more than 6 in. (150 mm) from the corridor wall, above the handrail height, shall be permitted.  
(3) Exit access within a room or suite of rooms

K 232

- 3) The Maintenance Supervisor is aware of the requirement/standard and there are no plans to change or place any fire extinguisher boxes in the building differently than the current placement.
- 4) The Maintenance Supervisor has received education from the Administrator regarding the importance of this NFPA standard; this was completed by 01/15/19.
- 5) The results of this survey will be reviewed by the quality committee in the December and January QAPI meetings. The QAPI meetings will be held on 12/20/18 and 01/22/19. Further action by the QAPI team will be taken if necessary at that time.

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NAME OF PROVIDER OR SUPPLIER  
  
BENNETT HILLS REHABILITATION AND CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE  
1220 MONTANA STREET  
GOODING, ID 83330

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K 232 Continued From page 2  
complying with the requirements of 19.2.5 shall be permitted.  
(4) Projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met:  
(a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in. (1525 mm).  
(b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency.  
(c)\*The wheeled equipment is limited to the following:  
i. Equipment in use and carts in use  
ii. Medical emergency equipment not in use  
iii. Patient lift and transport equipment  
(5) \*Where the corridor width is at least 8 ft (2440 mm), projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met:  
(a) The fixed furniture is securely attached to the floor or to the wall.  
(b) The fixed furniture does not reduce the clear unobstructed corridor width to less than 6 ft (1830 mm), except as permitted by 19.2.3.4(2).  
(c) The fixed furniture is located only on one side of the corridor.  
(d) The fixed furniture is grouped such that each grouping does not exceed an area of 50 ft<sup>2</sup> (4.6 m<sup>2</sup>).  
(e) The fixed furniture groupings addressed in 19.2.3.4(5)(d) are separated from each other by a distance of at least 10 ft (3050 mm).  
(f)\*The fixed furniture is located so as to not obstruct access to building service and fire protection equipment.  
(g) Corridors throughout the smoke compartment are protected by an electrically supervised

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K 232 Continued From page 3  
automatic smoke detection system in accordance with 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space.  
(h) The smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.8.  
  
CMS Final Rule:  
  
SECTIONS 18.2.3.4(2) AND 19.2.3.4(2)-CORRIDOR PROJECTIONS  
This provision requires non-continuous projections to be no more than 6 inches from the corridor wall. In addition to following the requirements of the LSC, health care facilities must comply with the requirements of the ADA, including the requirements for protruding objects. The 2010 Standards for Accessible Design (2010 Standards) generally limit the protrusion of wall-mounted objects into corridors to no more than 4 inches from the wall when the object's leading edge is located more than 27 inches, but not more than 80 inches, above the floor.

K 232



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

C.L. "BUTCH" OTTER – Governor  
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DIVISION OF LICENSING & CERTIFICATION  
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3232 Elder Street  
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PHONE 208-334-6626  
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COPY

December 28, 2018

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

Provider #: 135134

**RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER**

Dear Mr. Ord:

On **December 18, 2018**, an Emergency Preparedness survey was conducted at Bennett Hills Rehabilitation And Care Center by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. Your facility was found to be in substantial compliance with Federal regulations during this survey.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, which states that the facility complies with the requirements of CFR 42, 483.70(a) of the federal requirements. This form is for your records only and does not need to be returned.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact this office at (208) 334-6626, option 3.

Sincerely,

Nate Elkins, Supervisor  
Facility Fire Safety and Construction

NE/Lj  
Enclosures

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

PRINTED: 01/10/2019  
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>12/18/2018</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BENNETT HILLS REHABILITATION AND CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1220 MONTANA STREET GOODING, ID 83330</b>
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E 000	<p>Initial Comments</p> <p>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. The Essential Electrical System is supplied by a propane powered, on-site automatic generator. Currently the facility is licensed for 80 SNF/NF beds and had a census of 30 on the date of the survey.</p> <p>The facility was found to be in substantial compliance during the annual Emergency Preparedness Survey conducted on December 18, 2018. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.</p> <p>The survey was conducted by:</p> <p>Linda Chaney Health Facility Surveyor Facility Fire Safety and Construction</p>	E 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X8) DATE <b>01/07/2019</b>
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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.