

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

PRINTED: 10/01/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/01/2020
NAME OF PROVIDER OR SUPPLIER BINGHAM MEMORIAL SKILLED NURSING & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 98 POPLAR STREET BLACKFOOT, ID 83221		
(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	
{E 000}	<p>Initial Comments</p> <p>On October 1, 2020, an off-site follow-up survey was conducted, substantiating compliance for deficiencies identified during the Emergency Preparedness survey conducted on August 27, 2020. Bingham Memorial Skilled Nursing and Rehabilitation was determined to be in substantial compliance with all Emergency Preparedness standards at this time.</p> <p>The surveyor completing this survey was:</p> <p>Linda Chaney Health Facility Surveyor Facility Fire/Safety and Construction</p>	{E 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.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135007	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE NF B. WING _____		(X3) DATE SURVEY COMPLETED R 10/01/2020
NAME OF PROVIDER OR SUPPLIER BINGHAM MEMORIAL SKILLED NURSING & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 98 POPLAR STREET BLACKFOOT, ID 83221		
(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	
{K 000}	<p>INITIAL COMMENTS</p> <p>On October 1, 2020, an off-site follow-up survey was conducted, substantiating compliance for deficiencies identified during the annual Fire/Life Safety survey conducted on August 27, 2020. Bingham Memorial Skilled Nursing and Rehabilitation was determined to be in substantial compliance with all Life Safety Code standards at this time.</p> <p>The surveyor completing this survey was:</p> <p>Linda Chaney Health Facility Surveyor Facility Fire/Safety and Construction</p>	{K 000}			

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

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