



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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P.O. Box 83720  
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October 10, 2019

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

Provider #: 135134

Dear Mr. Ord:

On **October 3, 2019**, a survey was conducted at Bennett Hills Rehabilitation And Care Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, 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/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated 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. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

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After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **October 21, 2019**. Failure to submit an acceptable PoC by **October 21, 2019**, may result in the imposition of penalties by **November 12, 2019**.

The components of a Plan of Correction as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **November 7, 2019 (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 **January 3, 2020**. A change in the seriousness of the deficiencies on **November 17, 2019**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **January 3, 2020** includes the following:

Denial of payment for new admissions effective **January 3, 2020**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, 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 April 3, **2020**, 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, CMS will provide you with a separate formal notification of that determination.**

If you believe these deficiencies have been corrected, you may contact Belinda Day, RN or Laura Thompson, RN, Supervisors Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; fax number: (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 **January 1, 2020** 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 **October 21, 2019**. If your request for informal dispute resolution is received after **October 21, 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, comments or concerns, please contact Belinda Day, RN, or Laura Thompson, RN, Supervisors, Long Term Care Program at (208)334-6626, option #2.

Sincerely,



Belinda Day, RN, Supervisor  
Long Term Care Program

bd/lj

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

PRINTED: 10/25/2019  
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>10/03/2019</b>
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>		
(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	INITIAL COMMENTS  The following deficiencies were cited during the federal recertification survey conducted at the facility from September 30, 2019 to October 3, 2019.  The surveyors conducting the survey were: Linda Zuschlag, RN, Team Coordinator Brad Perry, LSW Kim Saccomando, RN, MSN	F 000			
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)  §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.  The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.  §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;  §483.10(i)(3) Clean bed and bath linens that are in good condition;	F 584		10/27/19	

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

TITLE

(X6) DATE

Electronically Signed

10/23/2019

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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F 584	<p>Continued From page 1</p> <p>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);</p> <p>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;</p> <p>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and</p> <p>§483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and staff interview, it was determined the facility failed to ensure a resident was provided a clean and homelike environment. This was true for 1 of 12 residents (Resident #29) whose environment was observed. This deficient practice created the potential for harm if the resident felt embarrassed, disrespected, and/or degraded by odors from a stained recliner. Findings include:</p> <p>The facility's cleaning and disinfection policy, dated 3/2009, directed staff to clean and decontaminate resident equipment to include urine.</p> <p>This policy was not followed.</p> <p>Resident #29 was readmitted to the facility on 3/1/18, with multiple diagnoses including dementia and expressive language disorder (which usually affects vocabulary and grammar resulting in limited capacity for conversation).</p>	F 584	<p>F000 Bennett Hills Center provides this plan of correction without admitting or denying the validity or existence of the alleged deficiency. The Plan of Correction is prepared and executed solely because it is required by federal and state law.</p> <p>F584 SS=D</p> <p>1) The recliner that was found to have a strong urine smell and dark spots was removed from the facility when it was pointed out by the survey member on 10/2/19. We have an appropriate, comfortable, clean recliner that we are putting in place in the residents room to replace the other recliner.</p> <p>2) A review of the whole facility was completed by the License Nurse on</p>		

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F 584	Continued From page 2  Resident #29's quarterly Minimum Data Set assessment, dated 9/6/19, documented she was severely cognitively impaired.  On 9/30/19 at 11:01 AM, Resident #29's room had a strong urine odor with a more potent urine odor near her cloth recliner.  On 9/30/19 at 11:02 AM and 2:55 PM, and on 10/1/19 at 10:15 AM and 4:04 PM, and on 10/2/19 at 7:38 AM, Resident #29's recliner had 3 large dark spots which covered the seat and emitted a strong urine odor.  On 10/2/19 at 10:32 AM, CNA #1 (Certified Nursing Assistant) said Resident #29's recliner seat smelled of urine.  On 10/2/19 at 10:35 AM, the Housekeeping Manager said Resident #29's recliner seat was dry and smelled of urine. He said, since the recliner seat was cloth, it was hard to clean.  On 10/2/19 at 10:43 AM, the Maintenance Supervisor said Resident #29's recliner was a chair provided by the facility. He said he saw a stain which ran throughout the seat of the chair and smelled of urine. The Maintenance Supervisor said if the seat cushion was soaked through, the recliner needed to be replaced.	F 584	10/2/19 with no other recliners found to be in the same condition.  3) Weekly documentation of checking all recliners will be completed by the License Nurse or a designee staff member for 4 weeks to assure that the recliners don't have strong smells or dark spots on them.  4) The staff received education from the RN educator to look for smells and spots on recliners in the building and to bring this information to the House Keeping Manager immediately when noticed. Also Housekeeping is looking for these same issues each day as they clean and sanitize resident's rooms this was completed by 10/27/19.  5) The 4 weekly audits results performed by the License Nurse or designee will be reviewed by the Quality Committee in the October and November QAPI meetings. The QAPI meetings will be held on 10/15/19 and 11/19/19. Further action by the QAPI team will be taken if findings at that time.		