**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**A. BUILDING _____________________________**

**B. WING _____________________________**

**DATE SURVEY COMPLETED**

11/06/2019

**NAME OF PROVIDER OR SUPPLIER**

BENNETT HILLS REHABILITATION AND CARE CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1220 MONTANA STREET
GOODING, ID 83330

**ID PREFIX TAG**

**ID PREFIX TAG**

**ID PREFIX TAG**

**SUMMARY STATEMENT OF DEFICIENCIES**

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**INITIAL COMMENTS**

An off-site follow-up survey was completed on November 6, 2019. Bennett Hills Rehabilitation and Care Center was found to be in compliance with deficiencies cited during the recertification survey on October 3, 2019 survey, as of October 27, 2019.

The surveyor conducting the follow-up was Loretta Todd, R.N.

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

**TITLE**

**DATE**

Electronically Signed

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.