

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135132	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/07/2025
NAME OF PROVIDER OR SUPPLIER  Idaho State Veterans Home - Pocatello		STREET ADDRESS, CITY, STATE, ZIP CODE  1957 Alvin Ricken Drive Pocatello, ID 83201	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETES HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations and interviews, it was determined that the facility failed to treat each resident with respect and dignity. This was true for 1 of 4 residents (Residents #19) observed for covered urinary drainage bag. This deficient practice had the potential for residents to experience embarrassment, and low feelings of self-worth. Findings include: Resident #19 was admitted on [DATE] with readmit on 6/17/24, with multiple diagnoses including heart failure, diabetes, and obstructive uropathy (condition when urine cannot drain through the urinary tract). On 8/4/25 at 2:31 PM, Resident #19's urinary drainage bag was uncovered and visible from the open doorway of his room. On 8/4/25 at 3:26 PM, the DON stated the urinary drainage bag should have been covered and was not.</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on policy review, record review, and staff interview, it was determined the facility failed to ensure residents and their representative received assistance to exercise their right to formulate an Advance Directive. This was true for 10 of 54 residents (#1, #2, #4, #9, #19, #26, #27, #29, #46, and #55) whose records were reviewed for advance directives. This deficient practice created the potential for harm or adverse outcomes if the residents' wishes were not followed or documented regarding their advance care planning. Findings include: The facility's Residents Rights Regarding Treatment and Advance Directives policy dated March 2025, documented it is the policy of this facility to support and facilitate a resident's right to request, refuse, and/or discontinue medical or surgical treatment and to formulate advance directives.</p> <p>a. Resident #1 was admitted to the facility on [DATE], with multiple diagnoses including coronary artery disease, GERD (a chronic digestive disorder where stomach acid frequently flows back into the esophagus), and anemia (when the body doesn't have enough healthy red blood cells to carry oxygen to the body's tissues).</p> <p>Resident #1's medical record contained a POST but did not document an advance directive and no documentation the facility informed or provided written information concerning the right to formulate an advance directive.</p> <p>b. Resident #4 was admitted to the facility on [DATE], with multiple diagnoses including Afib (irregular heartbeat), hypertension (high blood pressure), and malnutrition.</p> <p>Resident #4's medical record contained a POST but did not document an advance directive and no documentation the facility informed or provided written information concerning the right to formulate an advance directive.</p> <p>c. Resident #27 was admitted to the facility on [DATE], with multiple diagnosis including non-traumatic brain dysfunction (brain damage not caused by external force), hyperlipidemia (elevated fats in the blood), and thyroid disorder (when the thyroid gland doesn't produce the right amount of hormones).</p> <p>Resident #27's medical record contained a POST but did not document an advance directive and no documentation the facility informed or provided written information concerning the right to formulate an advance directive.</p> <p>d. Resident #46 was admitted to the facility on [DATE], with multiple diagnosis including hypertension, diabetes, and PTSD.</p> <p>Resident #46's medical record contained a POST but did not document an advance directive and no documentation the facility informed or provided written information concerning the right to formulate an advance directive.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 8/5/25 at 12:41 PM, the Administrator stated he could not find advanced directives for residents #1, #2, #4, #9, #19, #26, #27, #29, #46, or #55 and no documentation the facility informed or provided written information concerning the right to formulate an advance directive.</p> <p>e. Resident #9 was admitted to the facility on [DATE], with multiple diagnoses including diabetes and heart failure.</p> <p>Resident #9's medical record contained a POST document but no advance directives document and no documentation the facility informed or provided written information concerning the right to formulate an advance directive.</p> <p>f. Resident #26 was admitted to the facility on [DATE], with multiple diagnoses including chronic kidney disease and post-traumatic stress disorder (PTSD).</p> <p>Resident #26's medical record contained a POST document but no advance directives document and no documentation the facility informed or provided written information concerning the right to formulate an advance directive.</p> <p>g. Resident #55 was admitted to the facility on [DATE], with multiple diagnoses including epilepsy (a chronic brain disorder characterized by recurrent, unprovoked seizures) and aphasia (a language disorder that affects a person's ability to communicate).</p> <p>Resident #55's medical record had a POA for healthcare dated 10/19/14, but she revoked the POA on 12/19/23. Resident #55's medical record contained a POST document but no advance directives document and no documentation the facility informed or provided written information concerning the right to formulate an advance directive.</p> <p>h. Resident #2 was initially admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnoses including coronary artery disease, hemiparesis (partial paralysis), and dementia.</p> <p>Resident #2's medical record contained a POST but did not document an advance directive and no documentation the facility informed or provided written information concerning the right to formulate an advance directive.</p> <p>i. Resident #19 was initially admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnoses including heart failure and diabetes.</p> <p>Resident #19's medical record contained a POST but did not document an advance directive and no documentation the facility informed or provided written information concerning the right to formulate an advance directive.</p> <p>j. Resident #29 was admitted to the facility on [DATE], with multiple diagnoses including dementia and muscle weakness.</p> <p>Resident #29's medical record contained a POST but did not document an advance directive and no documentation the facility informed or provided written information concerning the right to formulate an advance directive.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on policy review, record review, and staff interview, it was determined the facility failed to ensure resident's rights to be free from abuse were protected. This was true for 1 of 1 resident (Resident #61) whose record was reviewed for resident-to-resident abuse. This failure placed residents at risk for potential abuse and potential physical and psychosocial harm. Findings include: The facility Freedom from Resident Abuse, Neglect, Mistreatment, and Exploitation policy dated 2024, documented each resident has the right to be free from verbal, sexual, physical, and mental abuse. Resident #29 was admitted to the facility on [DATE], with multiple diagnoses including dementia and history of falling.</p> <p>Resident #29's care plan dated 9/19/24, documented as a focus, I can be intrusive into others space while interventions are listed as intervene, redirect and remove environment as needed and observe and report signs and symptoms of me posing danger to self and others and intervene as needed.</p> <p>Resident #61 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including diabetes and anxiety disorder.</p> <p>On 9/17/24 at 9:15 AM, Resident #29 approached and yelled to stop tapping on the fish tank, at Resident #61 who was cleaning the outside glass of the day room lounge fish tank. Both residents exchanged words loudly when Resident #29 struck Resident #61 across his face leaving 3 open scratches which drew blood.</p> <p>According to the facility investigation report of the incident 2 nurses and 2 CNAs were present when the incident began and observed Resident #29 hit Resident #61 leaving scratches on his face.</p> <p>Following the facility investigation of the 9/17/24 incident, the facility conducted additional education for all staff related to resident-to-resident abuse prevention.</p> <p>Resident #29 was reassigned to a different dining room table to allow for greater geographical separation between both residents. Staff were advised to continue to monitor both residents with no further issues occurring.</p> <p>Both residents continue to have positive interactions with each other, and both are comfortable with the plan to limit interactions with each other.</p> <p>Based on the corrective action taken by the facility and no other incidences of abuse, neglect, misappropriation of property, or exploitation to residents after 9/19/24, the facility was cited for past non-compliance.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of the Resident Assessment Instrument (RAI), record review, and staff interview, the facility failed to ensure residents Minimum Data Set (MDS) had correct assessment information. This was true for 1 of 16 residents (Resident #46) reviewed for accuracy of MDS assessments. This deficient practice created the potential for residents to have their mental health needs not met due to inaccurate assessments. Findings include:Chapter 3 of The Resident Assessment Instrument (RAI), revised 10/1/2024, documented if a resident is currently considered by the state level II PASRR (Preadmission Screening and Resident Review) process to have a serious mental illness, then section A1500 of the MDS should be marked yes.Chapter 5 of the RAI documented if an MDS assessment is found to have errors that incorrectly reflect the resident's status, that assessment must be corrected.Resident #46 was admitted to the facility on [DATE], with multiple diagnoses including hypertension, diabetes, and PTSD (a serious mental illness).Resident #46's MDS assessment dated [DATE], documented in A1500, he did not have a serious mental illness.Residents #46's level II PASRR dated 2/19/25, documented he had a diagnosis of PTSD.Resident #46's medical record did not document a correction was completed for section A1500 to his MDS dated [DATE].On 8/6/25 at 11:30 AM, the DON stated section A1500 of Resident #46's MDS should have been corrected after receiving the level II PASRR on 2/19/25.</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and staff interview, it was determined the facility failed to refer residents for further evaluation when residents were diagnosed with a major mental illness. This was true for 1 of 16 residents (Resident #35) reviewed for Pre-admission Screening and Resident Review (PASARR) Level II evaluations. This deficient practice had the potential to cause harm if residents' specialized services for mental health needs were not evaluated by an appropriate state-designated authority. Findings include: Resident #35 was admitted to the facility on [DATE], with multiple diagnoses including dementia and PTSD. Resident #35 Level I PASRR dated 6/6/25, was generated in Arizona and had not documented PTSD, which was documented in his medical record diagnoses. A Level II PASRR for Resident #35 had not been requested or completed as required in Idaho. On 8/6/25 at 2:35 PM, the DON stated they should have created an updated Level I PASRR documenting PTSD and requested a Level II PASRR and did not.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to follow the resident's comprehensive person-centered care plan. This was true for 2 of 16 residents (#9 and #35) whose care plans were reviewed. This deficient practice of not following care plans placed residents at risk to their health and wellbeing with negative outcomes if services were not provided or provided incorrectly. Findings include:a. Resident #9 was admitted to the facility on [DATE], with multiple diagnoses including diabetes and heart failure.On 8/4/25 at 8:30 AM, observed CNA #1 transfer Resident #9 from his wheelchair to his bed using a sit to stand device.Resident #9's physician orders related to assistive devices documented transfer stability for inability to bear weight related to CVA and left side hemiplegia and weakness.Resident #9's care plan documented that resident is a two person assist when transferred using a sit to stand device.b. Resident #35 was admitted to the facility on [DATE], with multiple diagnoses including dementia and PTSD.Resident #35's PTSD diagnosis had not been addressed with interventions in his care plan.On 8/6/25 at 2:37 PM, the DON stated Resident #9 should have been transferred with two persons per the care plan and had not been and Resident #35's PTSD diagnosis should have been care planned and was not.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on the facility Bowel Management Protocol, record review and staff interview, it was determined the facility failed to follow the facility bowel care standing order of delivering specific medications when residents do not have BM within 72 hours for 5 of 16 Residents (#5, #9, #11, #26, and #35) who records were reviewed for bowel and bladder care. This failed practice created the potential for residents to experience discomfort when medications were not administered according to the physician's order. Findings include: The facility Bowel Management Protocol dated 4/2018, documented a resident's bowel movement(s) will be documented in Point of Care every shift. The licensed nurse will write and implement standing orders for progressive bowel elimination intervention as follows:- Step 1 - Bisacodyl tab give 10 mg by mouth as needed for constipation if no BM X 48-72 hours.- Step 2 - Bisacodyl suppository, insert 1 suppository rectally as needed for constipation if no BM X 12-24 hours following Bisacodyl tabs administration.- Step 3 - Fleet Naturals cleansing enema, insert one dose rectally as needed for constipation if no BM X 12-24 hours after Bisacodyl suppository. May repeat X1 if no results in 12-24 hours.</p> <p>a. Resident #5 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including fracture of left femur and depression.</p> <p>Resident #5's medical record documented in the CNA Task Bowel Activity, he had a bowel movement on 7/17/25 documented at 20:09, and not again until 7/22/25 documented at 20:43, 120 hours later.</p> <p>Resident #5's MAR for July 2025, documented bowel management protocol had not been initiated between 7/17/25 and 7/22/25.</p> <p>b. Resident #11 was admitted to the facility on [DATE], with multiple diagnoses including Huntington's disease (inherited condition that affects brain cells) and anxiety.</p> <p>Resident #11's medical record documented the following in the CNA Task Bowel Activity:</p> <ul style="list-style-type: none"> <li>- he had a bowel movement on 7/9/25 documented at 11:17, and not again until 7/23/25 documented at 21:29.</li> </ul> <p>Resident #11's MAR for July 2025, documented the following bowel management protocol:</p> <ul style="list-style-type: none"> <li>- Step 1 had been initiated on 7/9/25 which did not result in documented BM.</li> <li>- Step 2 had been initiated on 7/14/25 which did not result in documented BM.</li> <li>- Step 3 had been initiated on 7/15/25, 7/16/25, 7/17/25, 7/18/25, 7/19/25, 7/20/25, 7/21/25, 7/22/25, which did not result in documented BM.</li> </ul> <p>c. Resident #26 was admitted to the facility on [DATE], with multiple diagnoses including chronic kidney disease and post-traumatic stress disorder.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #26's medical record documented in the CNA Task Bowel Activity, he had a bowel movement on 7/23/25 documented at 13:59, and not again until 7/28/25 documented at 14:00, 120 hours later.</p> <p>Resident #26's MAR for July 2025 documented the bowel management protocol was initiated for Resident #26 on 7/28/25.</p> <p>d. Resident #35 was admitted to the facility on [DATE], with multiple diagnoses including dementia and PTSD.</p> <p>Resident #35's medical record documented the following in the CNA Task Bowel Activity:</p> <ul style="list-style-type: none"> <li>- he had a bowel movement on 7/6/25 documented at 21:47, and not again until 7/12/25 documented at 21:44, 144 hours later.</li> <li>- he had a bowel movement on 7/15/25 at 13:39 and not again until 7/20/25 at 15:41, 120 hours later.</li> </ul> <p>Resident #35's MAR for July 2025 documented the following bowel management protocol:</p> <ul style="list-style-type: none"> <li>- Step 1 had been initiated on 7/10/25 which did not result in documented BM.</li> </ul> <p>On 8/6/25 at 2:38 PM, the DON stated the nursing staff should have documented they followed the bowel protocol step 1, 2, and 3 and had not.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and staff interview, it was determined the facility failed to ensure accurate use of over the counter (OTC) medication left at bedside, and controlled medications were tracked and kept secure from potential theft and/or diversion. This was true for 1 of 16 residents (Resident #55) and the facility. This failure created the potential for undetected misuse of medications and/or diversion of controlled medications and had the potential to affect all residents who received medication in the facility. Findings include:</p> <p>a. Resident #55 was admitted to the facility on [DATE], with multiple diagnoses including epilepsy and aphasia (a neurological condition that affects a person's ability to communicate).</p> <p>On 8/4/25 at 8:15 AM, observed in Resident #55's room on the bedside table a bottle of Tylenol and Nyquil. There was a physician's order for the Tylenol but not the Nyquil.</p> <p>8/6/25 at 2:41 PM, the DON stated residents often bring in OTC medicines and don't tell nursing staff of the recent purchase. When nursing staff see the medicines at the bedside, they should get a physician's order and had not.</p> <p>b. On 8/5/25 at 9:42 AM, during [NAME] Hall medication cart audit, observed the narcotic accountability record, dated 8/1/25 to 8/5/25, with 1 licensed nurse signature not documented.</p> <p>On 8/5/25 at 9:44 AM, LPN #7 stated two nurses should have signed the narcotic accountability record when they accepted the medication cart or released the medication cart.</p> <p>On 8/5/25 at 3:12 PM, the DON stated two nurses should have signed the narcotic accountability record when they accepted the medication cart or released the medication cart.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, and staff interviews it was determined the facility failed to ensure medications were stored and kept secure, and biologicals were labeled when opened. This was true for 1 of 16 Residents (Resident #46) and the facility. These deficient practices created the potential for theft or misuse of medication and the use of expired biologicals. Findings include:</p> <ol style="list-style-type: none"> <li>The following was observed for biologicals. <ul style="list-style-type: none"> <li>On [DATE] at 10:25 AM, one set of glucose test solutions were not dated with the open date or the expiration date.</li> <li>On [DATE] at 10:27 AM, LPN #2 stated the glucose test solutions were not dated and should have been.</li> <li>On [DATE] at 10:50 AM, RN #9 stated glucose test solution bottles should be dated when opened and were not.</li> </ul> </li> <li>Resident #46 was admitted to the facility on [DATE], with multiple diagnoses including hypertension, diabetes, and PTSD. <ul style="list-style-type: none"> <li>On [DATE] at 9:40 AM, Resident #46's morning medications was observed sitting in a medication cup on his bedside table in his room with no licensed nurse present.</li> <li>On [DATE] at 9:45 AM, RN #2, stated she had no idea if Resident #46 had a self-medication administration assessment because this was her first day working with him.</li> <li>On [DATE] at 3:19 PM, RN #9 stated RN #2 is an agency nurse, and this was her first day working with Resident #46. He stated RN #2 should not have left Resident #46's medications at the bedside and left the room.</li> <li>On [DATE] at 11:33 AM, the DON stated Resident #46 was not approved to self-administer medications and RN #2 should not have left his medications at the bedside.</li> </ul> </li> </ol>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, staff interview, and record review it was determined the facility failed to ensure infection control prevention practices were maintained to provide a safe and sanitary environment. This was true for 4 of 16 residents (#9, #21, #22, and #36) and the facility observed for infection control. These failures put residents at risk for cross contamination and infection. Findings include:</p> <p>1. Resident #9 was initially admitted to the facility on [DATE], with readmission on [DATE], with multiple diagnoses including coronary artery disease and diabetes.</p> <p>Resident #9's medication orders included administer Novolog 100u/ml per sliding scale and Glargine 19u every AM.</p> <p>On 8/6/25 at 8:35 AM, observed RN #2 place a syringe containing Novolog insulin and a syringe containing Glargine insulin on Resident #9's bed next to him as she cleaned the injection site. RN #2 then picked up each syringe off the bed and administered the insulin to Resident #9.</p> <p>On 8/6/25 at 8:38 AM, RN #2 stated she should have placed the insulin syringes on a protective barrier on Resident # 9's bedside table, not in his bed.</p> <p>On 8/7/25 at 9:38 AM, the IP stated RN #2 should have placed her resident medications on a protective cover on top of Resident #9's bedside table, not in his bed.</p> <p>2. The facility's Equipment/Supplies Cleaning/Disposal Schedule policy, revised 4/20, stated shared equipment such as but not limited to: vital carts&amp;hellip;etc. will be disinfected between each use with disinfectant wipes.</p> <p>On 8/6/25 at 8:30 AM, observed Resident #36 in East hallway at RN #2's medication cart when RN #2 removed the blood pressure cuff from the vital cart and placed the blood pressure cuff on him, then removed the cuff and placed the blood pressure cuff back into the vital cart basket.</p> <p>On 8/6/25 at 8:42 AM, observed Resident #21 in East hallway at RN 2's medication cart. RN #2 removed the blood pressure cuff from the vital cart and placed on Resident # 21's arm then removed the cuff and placed the blood pressure cuff back into the vital cart basket.</p> <p>On 8/6/25 at 9:07 AM, RN #2 stated she should had cleaned the blood pressure cuff between resident uses and had not.</p> <p>On 8/7/25 at 9:38 AM, the IP stated blood pressure cuffs should be cleaned between resident uses and RN #2 had not followed the policy.</p> <p>3. On 8/4/25 at 8:30 AM, observed CNA #1 clean a sit to stand device after a resident transfer but she did not clean the strap used during the transfer. CNA #1 stated she was not sure when the straps get washed. After CNA #1 cleaned the sit to stand device she draped the dirty straps over the cleaned device.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135132	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/07/2025
NAME OF PROVIDER OR SUPPLIER  Idaho State Veterans Home - Pocatello		STREET ADDRESS, CITY, STATE, ZIP CODE  1957 Alvin Ricken Drive Pocatello, ID 83201	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/6/25 at 2:36 PM, the DON stated the lift straps should have been cleaned and not just draped over the cleaned lift.</p>