

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135148	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/11/2025
NAME OF PROVIDER OR SUPPLIER Idaho State Veterans Home - Post Falls		STREET ADDRESS, CITY, STATE, ZIP CODE 590 S Pleasant View Rd Post Falls, ID 83854	

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)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135148	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/11/2025
NAME OF PROVIDER OR SUPPLIER Idaho State Veterans Home - Post Falls		STREET ADDRESS, CITY, STATE, ZIP CODE 590 S Pleasant View Rd Post Falls, ID 83854	
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)		
F 0686 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview and record reviews, it was determined the facility failed to prevent the worsening of a pressure ulcer. This was true for 1 of 3 residents (Resident #1) reviewed for pressure ulcer. This deficient practice caused harm to Resident #1 when his pressure ulcer to his right heel deteriorated and became infected. Findings include: The State Operations Manual (SOM) Appendix PP stated a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Resident #1 was admitted to the facility on [DATE] with multiple diagnoses including dementia, heart failure and diabetes and chronic kidney disease. Resident #1's record documented the following: 1. Pressure Ulcer to Right Heel: A Weekly Pressure Ulcer Record documented the following: -7/24/25: Unstageable DTI measured 3.7 cm x 5.5 cm, intact, wound bed not visible, area with bruised appearance, Cleanse with wound cleanser and apply skin prep two times a day. -9/23/25: Unstageable DTI measured 5.5 cm x 6.6 cm, slough present, unstable eschar, with moderate amount of light red/pink discharge, redness and maceration noted on the periwound, no odor. Treatment: cleanse with wound cleanser, apply skin prep and cover with foam dressing. -9/30/25: Stage IV measured 6.3 cm x 7.6 cm, worsening condition, 100% unstable yellow slough and black eschar and draining, with cloudy, yellow/tan discharge, rotten smelling odor noted, redness and warmth on the periwound, wound edges was irregular and macerated due to increased drainage related to eschar becoming unstable. Treatment: cleanse the area with wound cleanser, apply silver alginate and cover with foam dressing. 10/7/25: Unstageable Pressure Ulcer measured 6.2 cm x 7.0 cm, infection was suspected, decline in wound healing, with copious amount of cloudy yellow/tan drainage, slough, eschar present, increase in foul smelling odor, maceration to edges of the wound. Treatment: cleanse the area with wound cleanser, apply silver alginate and cover with foam dressing, wound culture obtained, pain with wound care. -10/14/25: continues to have foul odor, wound culture was positive, and antibiotic was started, pain with wound care. Physician stated, Likely will need debridement. -10/21/25: antibiotic completed, wound improved in appearance. 10/28/25: copious amount of drainage and increase in odor noted, antibiotic was restarted. 2. Pressure to Left Heel: A Weekly Pressure Ulcer Record documented the following: -7/24/25: Unstageable Suspected Deep Tissue Injury (DTI), 7.0 x 4.5, intact, wound bed not visible, area with bruised appearance. Cleanse with wound cleanser and apply skin prep two times a day and cover with heel protector. -9/23/25: Unstageable with 100% stable black eschar, measured 4.5 x 6.8, Cleanse with wound cleanser, paint with betadine and cover with foam dressing. -9/30/25: Unstageable with 100% thick black eschar remains stable. Wound clinic referral done on 9/25/25 waiting for approval (name of hospital). -10/7/25: Unstageable with 100% thick black eschar remains some lifting at edges, measured 3.2 x 5.5. -10/14/25: Unstageable with 100% thick black eschar, measured 3.2 x 4.1, improvement noted in size of the wound. -10/21/25: Unstageable with 100% thick black eschar, measured 2.0 x 3.9. -10/28/25: Unstageable with 100% eschar but feels soft and drainage was now noted. The Weekly Pressure Ulcer Record was requested from the HIM. There was one Weekly Pressure Ulcer Record in July 2025. Resident #1 did not have a Pressure Ulcer Record for his left and right heel from 8/1/25 to 9/22/25. Progress Notes: -7/10/25 at 10:40 AM, had three deep tissue injury (DTI) to his left heel and left great toe, and to his right heel. An order was received to cleanse the DTI with wound cleanser, apply skin prep and allow to dry. -7/12/25 at 2:54 PM, had small open area to his left heel with small amount of red and brown blood noted. The area was cleansed, calcium alginate was placed over the open area, covered with non-adhesive heel protector, and wrapped with Kerlix (woven cotton fabric). -9/8/25 at 5:24 PM, had an open area to his right heel. An order was received to cleanse the area with wound cleanser, apply skin prep and cover with adhesive foam dressing every other day and as needed. -9/20/25 at 5:05 PM, odor was noted to be present to his right heel. -9/25/25 Nurse Practitioner's Notes documented concern with non-healing with eschar present requests wound care clinic evaluation for debridement and further recommendations. -10/12/25 Wound Culture, obtained from Resident #1's right foot documented the presence of Streptococcus agalactiae (bacteria). -10/14/25: continues to have foul odor, wound culture was positive, and antibiotic was started, pain with wound care. Physician stated, Likely will need debridement. -10/21/25: antibiotic completed, wound improved in appearance. 10/28/25: copious amount of drainage and increase in odor noted, antibiotic was restarted. Treatment Administration Record documented the following: - July, August and September 2025: cleanse left and right</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135148	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/11/2025
NAME OF PROVIDER OR SUPPLIER Idaho State Veterans Home - Post Falls		STREET ADDRESS, CITY, STATE, ZIP CODE 590 S Pleasant View Rd Post Falls, ID 83854	
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 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate foot care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, it was determined the facility failed to ensure resident was seen by a podiatry as ordered by the physician. This was true for 1 of 1 resident (Resident #1) reviewed for foot care. This deficient practice created the potential for Resident #1 to experience ongoing thickening of his toenails or other complications due to lack of foot care. Findings include:Resident #1 was admitted to the facility on [DATE] with multiple diagnoses including dementia, heart failure and diabetes.A nursing progress notes, dated 7/31/25 documented Resident #2's health care coordinator would be looking for a podiatrist for a referral to be seen for diabetic foot care.A nursing progress note dated 8/15/25 documented Resident needs a referral from his primary care to see the selected podiatrist for nail care. Form waiting for processing and signature.A physician assistant's progress notes, dated 8/22/25 documented the physician assistant agreed for Resident #1 to be seen by a podiatrist.On 11/11/25 at 11:26 AM, the Wound nurse was observed to change the wound dressings on Resident #1's right and left heels. Resident #2's toenails were observed to be thick, yellowish in color, and misshapen or raised from the nailbeds.Resident #2's record documented he was scheduled to be seen by a Podiatry on 11/12/25. That is about 10 weeks from the date the physician assistant agreed for him to be seen by a podiatrist.On 11/11/25 at 9:21 AM, the Wound Nurse stated Resident #1 had dysphoric (thick, oddly shaped or colored yellow or brown) toenails and it was difficult for them to cut his toenails. When asked about Resident #1's podiatry appointment, the Wound Nurse stated she believed the request was for Resident #1 to be seen by a podiatry for his toenails and consultation for a diabetic shoe. The Wound nurse stated she did not know why Resident #2's appointment took so long to be scheduled.On 11/11/25 at 9:45 AM, the HIM stated she believed she was informed of Resident #1 needing a podiatry in September 2025 and asked the Unit Clerk to submit the necessary paper works, but it was rejected by the [name of hospital] because they don't have Resident #1's information. The HIM stated they found out that Resident #1's being a veteran his care was needed to be transferred from his previous care provider to his current care provider for him to be scheduled for his podiatry appointment. The HIM stated Resident #1's representative needs to make this call to initiate the transfer. The HIM stated they were not aware of this procedure. She stated they thought Resident #1 being a veteran could go to any (name of hospital) for his treatment. When Resident #1's representative made the call, HIM stated Resident #1 paperwork was resent about three times and several phone calls were made to follow up his podiatry appointment.When asked if Resident #1 was referred to a private medical provider, since he had another medical insurance. The HIM stated she made phone calls to a podiatry clinic and was told there was a copay to be paid. The HIM stated Resident #1's representative refused to pay the copay. Other clinic would not accept Resident #1's insurance.On 11/11/25 at 10:05 AM, the CEO stated lots of veteran's families would like their family to be seen at a (name of hospital) and they don't want to be seen outside of the VA (Veterans Affairs) system. The CEO stated unfortunately the (name of hospital) was having a staffing crisis and they can only see so many residents in general. We were not aware of the need for the resident's care to be transferred from one (name of hospital) to another (name of hospital). I have been trying to get a podiatry contract for over a year, but no one was accepting it.</p>		