



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7012 3050 0001 2128 2545

September 24, 2013

Joshua Thompson, Administrator
Idaho State Veterans Home-- Pocatello
1957 Alvin Ricken Drive
Pocatello, ID 83201-2727

Provider #: 135132

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Thompson:

On **September 16, 2013**, a Facility Fire Safety and Construction survey was conducted at **Idaho State Veterans Home - Pocatello** by the Department of Health & Welfare, 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 Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread 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 and a similar State Form 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. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when you allege that each

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tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign both Statement of Deficiencies and Plan of Correction, Form CMS-2567 and State Form, in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **October 7, 2013**. Failure to submit an acceptable PoC by **October 7, 2013**, may result in the imposition of civil monetary penalties by **October 27, 2013**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

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 **October 21, 2013**, (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 **October 21, 2013**. A change in the seriousness of the deficiencies on **October 21, 2013**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **October 21, 2013**, includes the following:

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Denial of payment for new admissions effective **December 16, 2013**.
42 CFR §488.417(a)

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, 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 **March 16, 2014**, 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, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Mark P. Grimes, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, Fax #: (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 **September 16, 2013**, 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 7, 2013**. If your request for informal dispute resolution is received after **October 7, 2013**, 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, please contact us at (208) 334-6626.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. P. Grimes', with a long horizontal flourish extending to the right.

Mark P. Grimes, Supervisor
Facility Fire Safety and Construction

MPG/lj
Enclosures

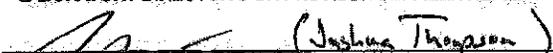
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 09/23/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 09/16/2013
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NAME OF PROVIDER OR SUPPLIER IDAHO STATE VETERANS HOME - POCATELL	STREET ADDRESS, CITY, STATE, ZIP CODE 1957 ALVIN RICKEN DRIVE POCATELLO, ID 83201
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(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	INITIAL COMMENTS The facility is a single story, type II(111) fire resistive fully sprinklered building built in 1992-93. Smoke detection coverage is provided throughout the facility including sleeping rooms. There is a lower level mechanical room with only exterior access. Currently the facility is licensed for 66 beds. The following deficiencies were cited during the annual fire/life safety survey conducted on September 16, 2013. The facility was surveyed under the National Fire Protection Association 101 LIFE SAFETY CODE 2000 Edition, Existing Health Care Occupancy and 42 CFR 483.70. The survey was conducted by: Tom Mroz CFI-II Health Facility Surveyor Facility Fire/Life Safety and Construction	K 000	Preparation and /or execution of this Plan of Correction (PoC) is not an admission of guilt nor does the provider agree with the conclusions set forth in the Statement of Deficiencies rendered by the Bureau. The Plan of Correction is prepared and executed simply as a requirement of federal and state law. We maintain that the alleged deficiencies do not individually, or collectively, jeopardize the health and safety of our residents, nor are they of such character as to limit this provider's capacity to render adequate resident care. Furthermore, the provider asserts that it is in substantial compliance with regulations governing the operation and licensure of skilled nursing facilities, and this document, in its entirety, constitutes this providers claim of compliance. Completion dates are provided for the procedural procession purposes to comply with the state and federal regulations, and correlate with the most recent contemplated or accomplished corrective action. These dates do not necessarily correspond chronologically to the date the provider is under the opinion it was in compliance with the requirements of participation or that corrective actions was necessary.	
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This Standard is not met as evidenced by: Based on observation and interview, the facility	K 025	K 025 Specific Residents: Twenty (20) residents and staff located near the medical storage room have the potential to be affected. Specific Staff: Staff in the smoke compartment that includes the medical storage room.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 10/7/13
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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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NAME OF PROVIDER OR SUPPLIER IDAHO STATE VETERANS HOME - POCATELL		STREET ADDRESS, CITY, STATE, ZIP CODE 1857 ALVIN RICKEN DRIVE POCATELLO, ID 83201		
(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 025	Continued From page 1 failed to maintain the smoke resistive properties of a smoke barrier ceiling. Openings in smoke barriers can allow smoke and fire gasses to enter other smoke compartments in the event of a fire. The deficient practice affected one of four smoke compartments, staff, and 20 residents. The facility has the capacity for 66 beds with a census of 48 the day of survey. Findings include: Observation on 09/16/13 at 3:05 p.m., revealed a missing 2' x 2' ceiling tile in the medical storage room. Interview with the facility Maintenance Engineer revealed that contractors were working in the ceiling space yesterday and they had forgotten to put the ceiling tile back in place. Actual NFPA Standard: NFPA 101, 19.3.7.3. Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour.	K 025	Systemic Changes: A new vendor exit checklist has been made that outline potential issues that could arise when the vendor leaves the work area at the end of the project. Procedural Changes: The Vendor Exit Checklist will be completed by the Building Foreman or Designee following the completion of the project and prior to the Vendor exiting the facility. Monitor: A audit will be completed by the Administrator or Designee weekly x 2 weeks and monthly x 2 months of the facility to ensure that the facility is completing the Vendor Exit Checklist. A audit will he completed by the Administrator or Designee weekly x 2 weeks and monthly x 2 months of the facility to ensure that ceiling tiles are in place and the smoke barrier is intact. Corrective actions will be completed : 10/07/2013	10/7/13
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This Standard is not met as evidenced by: Based on observation, operational testing, and staff interview, it was determined that the facility had not ensured exit doors are arranged to be opened readily from the egress side. These deficiencies can entrap people and prevent egress from the identified exits. The facility has the capacity for 66 beds with a census of 48 the	K 038		

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NAME OF PROVIDER OR SUPPLIER IDAHO STATE VETERANS HOME - POCATELL		STREET ADDRESS, CITY, STATE, ZIP CODE 1957 ALVIN RICKEN DRIVE POCATELLO, ID 83201		
(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 038	<p>Continued From page 2 day of survey. Findings include:</p> <p>During operational testing of the doors labeled "EXIT" on the A, B, C and D Wing exit doors on 09/16/13 between 2:00 p.m. and 4:00 p.m., disclosed that the magnetic door lock would not open without entering a code into the key code mechanism. Interview with the Maintenance Engineer indicated the facility was not aware that the locking arrangements were not code compliant.</p> <p>Actual NFPA Standards:</p> <p>NFPA 101® Life Safety Code ® 2000 Edition Means of Egress Components 7.2.1.5.1 Doors shall be arranged to be opened readily from the egress side whenever the building is occupied. Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side.</p> <p>Chapter 19 Existing Health Care Occupancies 19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1: Door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. (See 19.1.1.1.5 and 19.2.2.2.5.) Exception No. 2*: Delayed-egress locks complying with 7.2.1.6.1 shall be permitted, provided that not more than one such device is located in any egress path.</p>	K 038	<p>K 038 Residents: All Residents in the facility were affected by the exit doors not following the proper standard for egress doors. Procedural Changes: The exit doors on A, B, C, D wing exits will be fixed to include a delayed egress. Until the delayed egress is installed, exit doors A, B, C and D will be unlocked. A waiver has been requested to extend the timeframe of the project due to time constraints with the bidding process and manufacturer. Corrective actions will be completed : 10/07/2014</p>	10/07/13

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K 038	Continued From page 3 Exception No. 3: Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted.	K 038		
K 147 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure electrical wiring was in accordance with the National Electrical Code. Utilizing relocatable power taps can lead to overloaded wiring and start a fire. This deficient practice affected one of four smoke compartments, staff, and residents on the day of the survey.</p> <p>Findings include:</p> <p>Observation and interview on 08/16/13 at 2:41 p.m. revealed two vending machines plugged into a relocatable power tap that was plugged into a wall outlet in the Canteen. Interview with the Maintenance Engineer indicated the facility was not aware the vending contractor utilized a relocatable power tap for the vending machines. The power tap was removed in the presence of the surveyor.</p> <p>Actual NFPA Standard(s): NFPA 70,110-3. Examination, Identification, Installation, and Use of Equipment (a) Examination. In judging equipment, considerations such as the following shall be evaluated: 1. Suitability for installation and use in conformity with the provisions of this Code FPN: Suitability of equipment use may be</p>	K 147	<p>K 147</p> <p>Residents: Any residents and staff located near the canteen and in the smoke compartment located therein.</p> <p>Procedural Changes: The Vendor Exit Checklist will be completed by the Building Foreman or Designee following the completion of the project and prior to the Vendor exiting the facility.</p> <p>Monitor: A audit will be completed by the Administrator or Designee weekly x 2 weeks and monthly x 2 months of the facility to ensure that the facility is completing the Vendor Exit Checklist. A audit will be completed by the Administrator or Designee weekly x 2 weeks and monthly x 2 months of the facility to ensure that relocatable power taps are properly used.</p> <p>Corrective actions will be completed : 10/07/2013</p>	10/7/13

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K 147	Continued From page 4 identified by a description marked on or provided with a product to identify the suitability of the product for a specific purpose, environment, or application. Suitability of equipment may be evidenced by listing or labeling. 2. Mechanical strength and durability, including, for parts designed to enclose and protect other equipment, the adequacy of the protection thus provided 3. Wire-bending and connection space 4. Electrical insulation 5. Heating effects under normal conditions of use and also under abnormal conditions likely to arise in service 6. Arcing effects 7. Classification by type, size, voltage, current capacity, and specific use 8. Other factors that contribute to the practical safeguarding of persons using or likely to come in contact with the equipment (b) Installation and Use. Listed or labeled equipment shall be installed and used in accordance with any instructions included in the listing or labeling.	K 147		

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NAME OF PROVIDER OR SUPPLIER IDAHO STATE VETERANS HOME - POCATELLO		STREET ADDRESS, CITY, STATE, ZIP CODE 1957 ALVIN RICKEN DRIVE POCATELLO, ID 83201		
(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) COMPLETE DATE
C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.</p> <p>The facility is a single story type II(111) fire resistive fully sprinklered building completed in 1993. Smoke detection coverage is provided throughout the facility including sleeping rooms. The structure has a lower level mechanical room with exterior access only. Currently the facility is licensed for 66 beds.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on September 16, 2013. The facility was surveyed under the National Fire Protection Association 101 LIFE SAFETY CODE 2000 Edition, Existing Health Care Occupancy and IDAPA 16.03.02 Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities.</p> <p>The survey was conducted by:</p> <p>Tom Mroz CF-II Health Facility Surveyor Facility Fire/Life Safety and Construction</p>	C 000		
C 226	<p>02.106 FIRE AND LIFE SAFETY</p> <p>106. FIRE AND LIFE SAFETY: Buildings on the premises used as facilities shall meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to health care facilities. This RULE: is not met as evidenced by: Refer to the following Federal "K" tags on the CMS - 2567:</p>	C 226	C 226 Please refer to the Federal "K" tag on the CMS 2567 - K025, K038, K147.	

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

[Signature] (Ashley Thompson)

Administrator

10/2/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 09/16/2013
NAME OF PROVIDER OR SUPPLIER IDAHO STATE VETERANS HOME - POCATELLO		STREET ADDRESS, CITY, STATE, ZIP CODE 1957 ALVIN RICKEN DRIVE POCATELLO, ID 83201		
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C 226	Continued From Page 1 1. K025 Ceiling Penetration. 2. K038 Locking Arrangements 3. K147 Relocatable Power Tap	C 226		

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.