STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505454	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Valley Hospital	22 W 1st Street Tonasket, WA 98855

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an anti-inflammatory medication (medication that reduces inflammation and pain), taken in conjunction with an anticoagulant (blood thinning) medication, was administered according to medical provider orders for 1 of 3 Residents (Resident 1). This failure resulted in the medication being administered in excess which may have contributed to bruising and placed the resident at risk for additional bleeding and worsening of their overall condition. Findings included:According to Medscape Drug Reference Database, https://reference.medscape.com/drug-interactionchecker, copyright 1994-2026, Eliquis (an anticoagulant medication) and Naproxen (an anti-inflammatory medication) have a serious interaction, as both medications decrease the ability of the body to form clots in the blood and can lead to excess bleeding. The database stated concurrent use of the two medications should be avoided or include dosage modifications. Record review showed Resident 1 admitted to the facility on [DATE] with a diagnosis of atrial fibrillation (irregular beating of the heart that can lead to the production of blood clots that then can break away from the heart and cause a heart attack or stroke). Resident 1 also took Eliquis daily to decrease the risk of stroke or heart attack.Review of progress note dated 12/02/2025, Staff C, Medical Doctor, indicated Resident 1 had pain in their knee and shoulders and could start Naproxen 250 mg BID (two times per day) for 2 weeks (for 14 days), and to initiate Naproxen 250 mg BID for short course if renal and gastrointestinal status allow. The progress note showed Staff B's, Resident Care Manager, initials on the top right corner with the date 12/10/2025.Record review of Resident 1's Medication Administration Record (MAR) showed on 09/10/2025 an was order entered for the Eliquis to be taken one time daily, and that the medication was to be administered daily until the resident discharged . The MAR showed on 12/02/2025 an order was entered for Naproxen two times daily and did not have an end date. Review of the MAR showed Naproxen was then administered two times daily until they discharged from the facility on 02/25/2026.Further record review showed a skin check was completed on 02/23/2026 at 8:35 PM after facility staff found significant dark blue/purple bruising to Resident 1's inner thighs, buttock and perineal region (external sexual organs located between legs). Record review of a skin assessment written on 02/24/2026 measured the bruising: right upper inner thigh 3 centimeters (cm) by 3cm, right upper inner thigh 7 cm by 4 cm, left upper inner thigh 8 cm by 4 cm, perineal area - did not measure.During an interview on 03/05/2026 at 3:10 PM, Staff B stated they entered the order for Naproxen into the MAR for Resident 1 on 12/02/2025. Staff B confirmed they entered the order without an end date. They also stated it was their initials on the MD progress note from the same date, indicating they had reviewed the MD note. Staff B could not recall why an end date had not been entered as ordered by Staff C.In an interview on 03/05/2026 at 3:10 PM, Staff A, Director of Nursing, confirmed Resident 1 was taking Eliquis on admission and started taking Naproxen on 12/02/2025. The Naproxen was to end after two weeks, but was entered into the MAR without an end date and Resident 1 continued to receive the medication until the resident discharged from the facility on 02/25/2026. Staff A stated the interaction between the two drugs could have caused the bruising identified on 02/23/2026.Reference: WAC 388-97-1060(3)(k)(i)

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