

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/16/2024
NAME OF PROVIDER OR SUPPLIER North Valley Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47328</p> <p>Based on observation, interview, and record review the facility failed to ensure the Minimum Data Set (MDS, assessment tool) accurately reflected the status of 1 of 11 sampled residents (Resident 31), reviewed for resident assessment. This failure placed residents at risk of inaccurate monitoring of resident status over time, unmet care needs, and diminished quality of life.</p> <p>Findings included .</p> <p>Review of the facility policy titled, Extended Care Resident Assessment revised August 2024, showed the facility would accurately conduct a comprehensive assessment for each resident upon admission and periodically thereafter. The assessment would include a dental status assessment by a Registered Nurse (RN) to the condition of the teeth, gums, and other structures of the oral cavity that may affect a resident's nutritional status, communication abilities, or quality of life. The assessment was to include the need for, and use of, dentures or other dental appliances. The policy showed the assessment would be completed within 14 calendar days after admission.</p> <p>Review of the Centers for Medicare and Medicaid Services Long Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.18.11 revised October 2023, showed the RAI consisted of three basic components: the Minimum Data Set (MDS), the Care Area Assessment (CAA) and the RAI utilization guidelines. The utilization of the three component of the RAI yields information about a resident's functional status, strengths, weaknesses, and preferences, as well as offered guidance on further assessment once problems were identified. The MDS must be accurate as of the assessment reference date (ARD).</p> <p>According to the admission assessment, dated 04/02/2024, Resident 31 admitted to the facility on [DATE] with diagnoses including cancer and muscle wasting. The assessment further showed Resident 31 was dependent on staff for oral hygiene and no oral or dental status concerns were identified. Resident 31 had severe cognitive impairment.</p> <p>Review of the 03/27/2024 nursing admission assessment showed Resident 31 had a partial denture, no mouth pain or chewing problems. The assessment showed no documentation regarding Resident 31's own teeth or their status.</p> <p>Review of the 03/28/2024 personal hygiene care plan showed Resident 31 was dependent on staff assist for oral care. No documentation was found regarding Resident 31's own teeth or their status.</p> <p>(continued on next page)</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 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the 04/29/2024 provider note showed Resident 31 had periodontal (infection of tissue that hold teeth in place) disease and referred Resident 31 for a dental evaluation and treatment.</p> <p>During observation on 11/13/2024 at 9:21 AM, Resident 31 laid in bed with a thick layer of white debris along their bottom teeth. When Resident 31 smiled and exposed their upper teeth, Resident 31 had some missing upper teeth and jagged discolored front teeth.</p> <p>During an interview on 11/15/2024 at 10:55 AM, Staff F, Nursing Assistant, stated Resident 31 had their own teeth but was missing some. Staff F was unsure if Resident 31 had broken or jagged teeth.</p> <p>In an interview on 11/15/2024 at 11:18 AM, Staff G, Registered Nurse, stated Resident 31 had their own teeth but they were not in very good shape.</p> <p>In an interview on 11/16/2024 at 12:44 PM, Staff C, Resident Care Manager, stated an MDS was an assessment tool to comprehensively collect data about a resident and should accurately reflect a resident's status as of the ARD. Staff C further stated if an MDS was inaccurate it could potentially affect a resident because the assessment helped drive clinical care for residents. Staff C reviewed Resident 31's medical record. Staff C acknowledged the admission nursing assessment for oral/dental was not filled out completely and the 04/02/2024 admission MDS did not accurately reflect Resident 31's dentation status as of the ARD.</p> <p>In an interview on 11/16/2024 at 3:55 PM, Staff B, Director of Nursing, reviewed Resident 31's medical record. Staff B acknowledged the 04/02/2024 admission MDS did not accurately reflect Resident 31's dental status as of the ARD and should have.</p> <p>Reference WAC 388-97- 1000 (2)(k)</p> <p>Refer to F656 and F791 for additional information.</p>		

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<p>F 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident when there is a significant change in condition</p> <p>46033</p> <p>Based on observation, interview and record review, the facility failed to determine a resident had a significant change in their physical condition for 1 of 11 sampled residents (Resident 27) reviewed for comprehensive assessments. This failure placed the resident at risk for unidentified care needs and a lack of revisions to their plan of care.</p> <p>Findings included .</p> <p>A review of the 06/16/2024 quarterly assessment documented Resident 27 had diagnoses including Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), and dementia with anxiety. Resident 27 had severe cognitive impairment, required partial/moderate assistance to eat, and substantial/maximum assistance for toileting, dressing, personal hygiene, and mobility in and out of bed.</p> <p>A review of the active 07/14/2022 comprehensive care plan documented Resident 27 had an ADL (activities of daily living) self-care deficit. The resident required set-up assistance for eating, supervision to extensive assistance for personal hygiene and dressing, extensive assistance for toileting and bed mobility, and 2-3 staff assistance for a stand and pivot method of transfers. Staff were to use a mechanical lift as needed.</p> <p>On 09/08/2024, the quarterly comprehensive assessment was completed and documented that Resident 27 required substantial/maximum assistance for eating and was totally dependent on staff for completion of their ADLs. A significant change assessment had not been completed for Resident 27. Changes were not made to the Resident 27's plan of care.</p> <p>On 11/12/2024 12:04 PM and 11/14/2024 at 11:53 AM, Resident 27 was observed in the dining room at lunch. The resident had a staff member seated next to them that fed the resident. Resident 27 had drinks that had lids on them with straws. Staff held the glass to Resident 27's mouth so they could drink.</p> <p>On 11/13/2024 at 12:10 PM Resident 27 was observed in their room. The resident was in their wheelchair with a mechanical lift sling around them that was connected to the mechanical lift (a machine that hoists a resident out of their seat or bed using a sling; the resident is passive when transferred, the staff and machine bear the weight of the resident). Staff P, Nursing Assistant, (NA) was present and waited for a second staff to assist the transfer.</p> <p>During an interview on 11/16/2024 at 9:35 AM, Staff P stated they had been employed at the facility for just over 2 months. They stated when they first started, Resident 27 was able to be transferred using a stand and pivot method, but currently had to use a mechanical lift. They stated Resident 27 used their arms slightly when putting on a top but did not assist dressing with their legs. Staff P stated they did not attempt to seat the resident on a commode; they were unsure if Resident 27 was able to support their trunk.</p> <p>(continued on next page)</p>		

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<p>F 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/16/2024 at 10:44 AM, Staff Q, NA, stated Resident 27 required total assistance. The resident required a mechanical lift for transfers and was unable to follow instructions such as when helping reposition or rolling the resident in bed. The resident also required staff to feed them, so they stayed right next to the resident at meals.</p> <p>During an interview on 11/16/2024 at 11:43 AM, Staff C, Resident Care Manager, stated the interdisciplinary team had discussed Resident 27's status but did not recall why a significant change assessment had not been done. Staff C stated a significant change assessment was important so it could be determined if a resident required more support services and so staff knew the appropriate level of care they needed to provide.</p> <p>During an interview on 11/16/2024 at 4:10 PM, Staff B, Director of Nursing, stated their internal audits had identified that the comprehensive assessment process had some areas that needed improvement, and they planned to continue working to improve the assessment process.</p> <p>Reference: WAC 388-97-1000(3)(b)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47328</p> <p>Based on interview and record review the facility failed to ensure Level I Preadmission Screening and Resident Review (PASRR, an assessment to ensure individuals with serious mental illness or intellectual/developmental disabilities were not inappropriately placed in nursing homes for long term care) was accurately completed for 1 of 6 sampled residents (Resident 6), reviewed for PASRR. In addition, the facility failed to routinely ensure residents with a positive Level I PASRR were referred for Level II PASRR evaluations, as required for 2 of 6 sampled residents (Resident 6 and 31). This failure placed the residents at risk for not receiving the care and services appropriate for their needs.</p> <p>Findings included .</p> <p><Resident 6></p> <p>According to the admission assessment, dated 04/14/2024, Resident 6 admitted to the facility on [DATE] with diagnoses including chronic pain. The assessment further showed Resident 6 did not demonstrate any behaviors or signs and/or symptoms of depression.</p> <p>Review of the 05/15/2023 PASRR showed Resident 6 had no serious mental illness indicators identified, and a Level II evaluation was not indicated.</p> <p>Review of the 05/16/2023 provider documentation showed Resident 6 took antipsychotic (medications used to treat symptoms of psychosis [mental disorder that cause abnormal perceptions and thoughts]) medications for visual hallucinations (false perception of an object or event that seems real but not) and antidepressant medication for moderate recurrent major depression.</p> <p>Review of the 05/17/2023 mood care plan showed Resident 6 received medication for depression and instructed staff to administer medications as ordered, documented behaviors and interventions attempted, monitor and document medication side effects.</p> <p>Review of provider orders showed an active 07/27/2023 order for Resident 6 to be administered an antidepressant and a 08/29/2023 order for Resident 6 to be administered an antipsychotic daily.</p> <p>Review of the 04/12/2024 neurologist (doctor that specializes in conditions that affect the brain and nerves) progress notes showed Resident 6 was to continue taking an antipsychotic due to a history of severe hallucinations.</p> <p>According to the quarterly assessment, dated 10/13/2024, over the last two weeks Resident 6 felt down, depressed, or hopeless several days. Resident 6's PASRR was not redone, and Resident 6 was not referred for a Level II evaluation, as required.</p> <p>Further review of the antipsychotic medication use care plan revised 10/31/2024 showed Resident 6 took medications related to a history of experiencing frightening hallucinations and instructed staff to administer medications as ordered, monitor and document medication side effects.</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><Resident 31></p> <p>According to the admission assessment, dated 04/02/2024, Resident 31 had diagnoses including depression and psychotic (severe mental illness that causes a person to lose touch with reality and have difficulty relating to others) disorder.</p> <p>Review of the 03/15/2023 PASRR showed Resident 31 had mood disorders, but a Level II evaluation was not indicated.</p> <p>According to the quarterly assessment, dated 09/29/2024, showed over the last two weeks Resident 31 felt down, depressed, or hopeless half or more days. Resident 31 had severe cognitive impairment. Resident 31's PASRR was not redone, and Resident 31 was not referred for a Level II evaluation, as required.</p> <p>Review of March 2024 through November 2024 nursing progress notes showed no documentation Resident 31 was referred for a PASRR Level II evaluation, as required.</p> <p>In an interview on 11/15/2024 at 12:48 PM, Staff E, Social Service Director, explained the facility typically received PASRRs prior to admission but if none was received Staff E completed a PASRR prior to a resident's admission. Staff E further stated a PASRR was redone if/when a resident had a change of condition. Staff E explained a positive Level I PASRR required a referral for a Level II evaluation from an assessor, but they had not referred any residents for a Level II PASRR evaluation in several years. Staff E stated if or when a Level II PASRR referral was submitted it would be documented in a progress note and care planned. Staff E reviewed Level I PASRRs for Resident 18 and Resident 31. Staff E acknowledged Resident 18 and Resident 31 were not referred for a Level II PASRR, as required.</p> <p>In an interview on 11/16/2024 at 5:04 PM Staff B, Director of Nursing, stated they expected staff to follow the appropriate PASRR process.</p> <p>Reference WAC 388-97-1915 (1)(2)(a-c)</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47328</p> <p>Based on observation, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan that included dentation status and needs for 1 of 11 sampled residents (Resident 31), reviewed for care planning. This failure placed residents at risk of unmet care needs and diminished quality of life.</p> <p>Findings included .</p> <p>According to the admission assessment, dated 04/02/2024, Resident 31 admitted to the facility on [DATE] with diagnoses including cancer and muscle wasting. The assessment further showed Resident 31 was dependent on staff for oral hygiene and no oral or dental status concerns were identified. Resident 31 had severe cognitive impairment.</p> <p>Review of the 03/27/2024 nursing admission assessment showed Resident 31 had a partial denture, no mouth pain or chewing problems. The assessment showed no documentation regarding Resident 31's own teeth or their status.</p> <p>Review of the 03/28/2024 personal hygiene care plan showed Resident 31 was dependent on staff assist for oral care. No documentation was found on goals or interventions developed regarding Resident 31's dentation status.</p> <p>Review of the 04/29/2024 provider note showed Resident 31 had periodontal (infection of tissue that hold teeth in place) disease and referred Resident 31 for a dental evaluation and treatment. No documentation was found in Resident 31's care plan regarding periodontal disease goals or interventions.</p> <p>Review of March 2024 through November 2024 nursing progress notes showed on 05/29/2024 Resident 31 did not allow their partial denture to be removed during oral care. On 09/06/2024 staff had difficulty removing extra food debris from Resident 31's lower teeth.</p> <p>During observation on 11/13/2024 at 9:21 AM, Resident 31 laid in bed with a thick layer of white debris along their bottom teeth. When Resident 31 smiled and exposed their upper teeth, Resident 31 had some missing upper teeth and jagged discolored front teeth.</p> <p>In an interview on 11/15/2024 at 10:55 AM, Staff F, Nursing Assistant, stated Resident 31 had their own teeth but some were missing. Staff F further stated Resident 31 was dependent on staff assist for oral care but sometimes refused oral care by turning their head and pushing away.</p> <p>In an interview on 11/15/2024 at 11:18 AM, Staff G, stated Resident 31 was dependent on staff for oral care. Staff G further stated Resident 31 had their own teeth, but they were not in very good shape.</p> <p>(continued on next page)</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>In an interview on 11/15/2024 at 11:36 AM, with Staff C, Registered Nurse Care Manager, and Staff D, Registered Nurse Care Manager. Staff C explained a dentation assessment included oral care needs, denture and natural tooth status. Staff C stated dentation was assessed upon admission using the nursing admission assessment which helped create a resident's care plan. Staff C stated Resident 31 had some of their own teeth and an upper partial denture. Both Staff C and Staff D reviewed Resident 31's medical record. Staff D acknowledged Resident 31's care plan showed no documentation regarding Resident 31's dental status but should have.</p> <p>In an interview on 11/16/2024 at 3:55 PM, Staff B, Director of Nursing, reviewed resident 31's medical record. Staff B acknowledged Resident 31's record did not accurately reflect Resident 31's dentation status and should have.</p> <p>Reference WAC 388-97-1020 (1), (2)(a)(b)</p> <p>Refer to F636 and F791 for additional information.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>46115</p> <p>Based on observation, interview, and record review, the facility failed to consistently provide grooming for 1 of 2 sampled residents (Resident 30), reviewed for activities of daily living. This failure placed the resident at risk for not being groomed according to their preferences, and a diminished quality of life.</p> <p>Findings included .</p> <p>According to the 09/29/2024 annual assessment, Resident 30 was cognitively intact and needed supervision/set up assistance from staff for ADL's (activities of daily living), such as personal hygiene.</p> <p>Per the 10/11/2023 care plan, Resident 30 had impaired vision and needed assistance with ADL's.</p> <p>Review of the personal hygiene task from 10/16/2024 through 11/13/2024 documented Resident 30 required partial to total assistance and had not refused cares.</p> <p>Review of the bathing task from 10/16/2024 to 11/13/2024 documented Resident 30 required partial to total assistance and had refused to be bathed twice.</p> <p>In an observation and interview on 11/12/2024 at 1:13 PM, Resident 30 was lying in their bed and stated they could not see well. Resident 30's nails were unclean with a brown substance underneath them.</p> <p>Subsequent observations of Resident 30 having unclean nails with brown matter under them were made on 11/13/2024 at 9:22 AM, 1:21 PM and 2:22 PM, 11/14/2024 at 09:22 AM and 1:05 PM and 11/16/2024 at 8:59 AM.</p> <p>During an interview on 11/14/2024 at 11:16 AM, Resident 30 stated they used their fingers to eat with and staff had not cleaned under their nails after meals.</p> <p>In an interview on 11/16/2024 at 9:36 AM, Staff H, Nursing Assistant, stated nail care was completed after showers and should have been completed after meals for residents that ate with their fingers to prevent bacteria.</p> <p>During an interview on 11/16/2024 at 9:52 AM, Staff B, Director of Nursing, stated nail care was completed with showers and confirmed nail care should have been provided after meals and this was important because nails can harbor bacteria.</p> <p>Reference: WAC 388-97-1060 (2)(c)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47328</p> <p>Based on interview and record review the facility failed to ensure residents administered psychotropic (drugs that alter brain function and could cause changes in mood, behavior, awareness, thoughts, or feelings) medications were adequately monitored and had indications for medication use documented in their medical record for 1 of 5 sampled residents (Resident 18), reviewed for unnecessary medications. This failure placed the residents at risk for receiving unnecessary medication and a diminished quality of life.</p> <p>Findings included .</p> <p>Review of the facility policy titled, Psychotropic Drug Monitoring revised August 2023, showed the facility would assess and monitor resident who received psychotropic medications in order to assist the physician in evaluating effectiveness of drugs, to prevent drug induced impairment, to ensure that residents did not receive these drugs unless therapy was necessary to treat a specific condition as diagnosed and documented in the clinical record and to ensure residents receiving these drugs received gradual dose reductions (GDR) and behavioral interventions in an effort to discontinue these drugs. The policy instructed staff to document behaviors observed in a progress note and notify social service staff and nurse management staff who would initiate behavior monitoring with specific targeted behaviors. Behavior monitoring was to be continued for the duration of the drug therapy.</p> <p>According to the quarterly assessment dated [DATE], Resident 18 had diagnoses including dementia, depression, Bipolar disorder (mental illness that caused changes in energy, thinking, behaviors, sleep and extreme mood swings) and post-traumatic stress disorder (PTSD, anxiety disorder that could develop after someone experienced or witnessed a traumatic event). The assessment further showed Resident 18 took antidepressant and antipsychotic (medications used to treat symptoms of psychosis [mental disorder that caused abnormal perceptions and thoughts]) medications. Resident 18 did not show signs and/or symptoms of depression or exhibit any behaviors which was unchanged from the previous assessment.</p> <p>Review of the 04/25/2024 hospital discharge orders showed Resident 18 was to be administered an antipsychotic and an antidepressant 100 milligrams (mg) daily.</p> <p>Review of the 04/26/2024 mood care plan showed Resident 18 took an antidepressant and antipsychotic medication and instructed staff to administer medications as ordered, document behaviors and interventions attempted, monitor and document signs and/or symptoms of depression.</p> <p>Review of April 2024 through May 2024 medication administration records showed no documentation Resident 18 experienced behaviors or signs and/or symptoms of depression.</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of April 2024 through July 2024 nursing progress notes showed Resident 18 pleasantly interacted with staff and residents, was cooperative with cares, and did not demonstrate mood or behavior concerns. On 04/30/2024 Resident 18's antipsychotic was decreased. Resident 18 had no change in mood or behavior related to decrease of their antipsychotic medication. On 05/09/2024 the provider gave further orders to decrease the antipsychotic slowly because Resident 18's Bipolar disorder was clinically stable at that time. Resident 18 had no mood or behavior changes observed. On 05/16/2024 Resident 18 reported feeling unmotivated, asked about an antidepressant, the provider increased Resident 18's antipsychotic back to the previous dose and increased their antidepressant to 150mg. No documentation was found to show behaviors or other signs and/or symptoms of depression Resident 18 experienced. On 07/09/2024 Resident 18's antidepressant was increased again, to 200mg.</p> <p>Review of the 05/07/2024 provider progress note showed Resident 18 did not demonstrate any behavior issues and took an antipsychotic medication for their Bipolar disorder. The provider's plan was to wean the antipsychotic medication slowly and monitor Resident 18.</p> <p>Review of the 06/04/2024 provider progress note showed nursing staff reported Resident 18's emotions were more labile and increased the antipsychotic back to the original dose.</p> <p>Review of May 2024 through August 2024 'task' behavior monitoring showed Resident 18 experienced behaviors on 05/12/2024, 06/02/2024, and 07/24/2024.</p> <p>Review of the 07/09/2024 provider progress note showed nursing staff reported Resident 18 was isolating and staying in [their] room more. Resident 18 requested an increase to their antidepressant. The provider increased Resident 18's antidepressant to 200mg.</p> <p>Review of the 05/01/2024, 07/28/2024, and 10/27/2024 depression questionnaires showed Resident 18 did not show signs and/or symptoms of depression.</p> <p>In an interview on 11/16/2024 at 2:15 PM, Staff E, Social Service Director, stated resident behaviors were monitored in the medication administration record, in the 'tasks', and documented in nursing progress notes. Staff E explained a psychotropic medication GDR was considered a failure based on the resident's behavior or depressive symptom changes. Staff E did not recall what behavioral changes Resident 18 experienced when their antipsychotic was reduced.</p> <p>In an interview on 11/16/2024 at 2:37 PM, Staff C, Resident Care Manager, stated resident's were placed on alert charting when a medication was reduced to monitor their tolerance. Staff C further stated Resident 18 was anxious when their medication was reduced and requested their medications back.</p> <p>In an interview on 11/16/2024 at 3:48 PM, Staff B, Director of Nursing, reviewed Resident 18's medical record. Staff B acknowledged Resident 18's behaviors should have been documented in further detail in their record.</p> <p>Reference WAC 388-97-1060 (3)(k)(i)</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain dental services for each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47328</p> <p>Based on observation, interview, and record review the facility failed to assist the resident in obtaining routine dental care as required for 1 of 1 sampled residents (Resident 31), reviewed for dental services. This failure placed residents at risk of unmet dental care needs and diminished quality of life.</p> <p>Findings included .</p> <p>Review of the facility policy titled, Physician Referrals revised November 2024, showed the facility would provide person-centered care by ensuring timely and appropriate referrals to external health care providers, community resources, and other specialized services. The policy further showed a referral was warranted if the facility was not able to meet a resident's needs within its scope of practice or available resources. Staff were to document the identified need the resident's medical record and update the resident's care plan to reflect any changes resulting from the referral. The policy further showed the facility would maintain records of all referrals, including the reason for the referral, consent forms, communication logs, and follow-up outcomes.</p> <p>According to the admission assessment, dated 04/02/2024, Resident 31 admitted to the facility on [DATE] with diagnoses including cancer and muscle wasting. The assessment further showed Resident 31 was dependent on staff for oral hygiene and no oral or dental status concerns were identified. Resident 31 had severe cognitive impairment.</p> <p>Review of the 03/27/2024 nursing admission assessment showed Resident 31 had a partial denture, no mouth pain or chewing problems. The assessment showed no documentation regarding Resident 31's own teeth or their status.</p> <p>Review of the 03/28/2024 personal hygiene care plan showed Resident 31 was dependent on staff assist for oral care. No documentation was found regarding Resident 31's dentation status.</p> <p>Review of the 04/29/2024 provider note showed Resident 31 had periodontal (infection of tissue that hold teeth in place) disease and referred Resident 31 for a dental evaluation and treatment.</p> <p>Review of provider orders as of 11/14/2024 showed no provider order for a dental evaluation or treatment.</p> <p>Review of March 2024 through November 2024 nursing progress notes showed on 05/29/2024 Resident 31 did not allow their partial denture to be removed during oral care. On 09/06/2024 staff had difficulty removing extra food debris from Resident 31's lower teeth. No documentation was found showing Resident 31 had been seen or evaluated by a dentist as requested by the provider on 04/29/2024.</p> <p>During observation on 11/12/2024 at 12:34 PM, Resident 31 had a thick layer of white debris along their lower teeth.</p> <p>(continued on next page)</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During observation on 11/13/2024 at 9:21 AM, Resident 31 laid in bed with a thick layer of white debris along their bottom teeth. When Resident 31 smiled and exposed their upper teeth, Resident 31 had some missing upper teeth and jagged discolored front teeth.</p> <p>In an interview on 11/15/2024 at 10:55 AM, Staff F, Nursing Assistant, stated Resident 31 had their own teeth but some were missing. Staff F further stated Resident 31 was dependent on staff assist for oral care but sometimes refused oral care by turning their head and pushing away.</p> <p>In an interview on 11/15/2024 at 11:18 AM, Staff G, Registered Nurse, stated provider notes were reviewed by nursing staff and nurse care managers processed any referrals requested by a provider.</p> <p>In an interview on 11/15/2024 at 11:36 AM, with Staff C, Resident Care Manager, and Staff D, Resident Care Manager. Staff C stated nurse managers reviewed provider documentation and followed up as needed on orders and/or referrals. Staff C further stated Resident 31 had some of their own teeth and an upper partial denture. Both Staff C and Staff D reviewed Resident 31's medical record and both staff stated they were unable to recall if Resident 31 had been seen by a dentist. Staff C contacted Resident 31's representative via phone. Resident 31's representative acknowledged Resident 31 had not been seen by a dentist since they admitted to the facility.</p> <p>In an interview on 11/16/2024 at 3:55 PM, Staff B, Director of Nursing, reviewed Resident 31's medical record. Staff B stated they expected staff to follow-up and process provider referrals.</p> <p>Reference WAC 388-97-1060 (3)(j)(vii)</p> <p>Refer to F636 and F656 for additional information.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46115</p> <p>Based on observation, interview, and record review, the facility failed to store food in accordance with professional standards for food service safety. Failure to ensure expired foods were discarded for 3 of 3 refrigerators, 1 of 1 dry storage areas, opened dates were placed on food items in the refrigerator and freezer and performed hand hygiene when indicated. The facility further failed to consistently monitor refrigerator and dish washer temperatures. These failures placed residents at risk for food-borne illnesses.</p> <p>Findings included .</p> <p><Expired/undated food></p> <p>During an initial tour of the kitchen on [DATE] at 11:17 AM, the dry storage area revealed a nut mix that was made on [DATE] with no expiration date, a can of trail mix with no expiration or open date, two boxes of brown rice that expired on [DATE], five bags of instant mashed potatoes that expired on [DATE], and a bag of opened toasted seeds that had no open or expiration date.</p> <p>The refrigerator in the main kitchen contained three packages of cheese and a large container of wilted grapes with no open or expiration date, a pan of bacon, five crescent rolls, onions, celery and cabbage that had no expiration date.</p> <p>The freezer contained a homemade cheesecake, a cake and a dessert in a bowl with no expiration date, a bag of opened tater tots, three opened bags of vegetables with no open or expiration date, a bag of opened strawberries that were unsealed and four frozen bananas with no open or expiration date.</p> <p>In an interview on [DATE] at 11:17 AM, Staff I, Dietary Manager, stated food needed to be dated for quality and safety.</p> <p>During an observation on [DATE] at 11:09 AM, the refrigerator in the dining room revealed three boiled eggs that expired on [DATE], and an opened package of cheese slices with no open or expiration date. The refrigerator in the snack room revealed a bag of frozen cookies and a bag of mixed berries with no date or expiration date, a container of muffins that were made on [DATE] with no expiration date, and French toast made on [DATE] with no expiration date.</p> <p><Dining Room Observation></p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During observation on [DATE] at 11:57 AM, Staff M, Dietary Aide, wore a pair of purple gloves, walked across the common hall from kitchen counter in the large assisted dining room into the small dining lounge to deliver an uncovered plate of food to Resident 24. Without removing their gloves or performing hand hygiene, Staff M walked back across the common hall to the kitchen counter in the large assisted dining room. At 11:59 AM, Staff M walked back to the small dining lounge to deliver and set up an uncovered plate of food for Resident 38. Without removing their gloves or performing hand hygiene, Staff M approached the kitchen counter in the large assisted dining room. Staff M delivered an uncovered plate of food for Resident 4. At 12:01 PM, Staff M picked an item off the floor with their right hand, removed their right glove, did not perform hand hygiene and applied a new glove. At 12:04 PM, Staff M delivered an uncovered plate of food to Resident 37. At 12:08 PM, without removing their gloves or performing hand hygiene, Staff M obtained coffee for Resident 23.</p> <p>In an interview on [DATE] at 12:24 PM, Staff N, Licensed Practical Nurse, acknowledged food should always be covered when transporting.</p> <p>In an interview on [DATE] at 12:34 PM, Staff C, Resident Care Manager, stated food should be covered when transported down the hall to prevent potential bacterial contamination.</p> <p>In an interview on [DATE] at 3:31 PM, Staff B, Director of Nursing, acknowledged staff did not cover food when transporting food from the assisted dining room kitchen counter across the common hallway and delivering to the small dining lounge because the common hall was considered part of the dining room area.</p> <p><Food Temperatures></p> <p>During observation of tray line on [DATE] at 11:26 AM, Staff O, Cook, had plated a chicken breast on a plate that they had removed from a heated cart and was going to serve the chicken to a resident. When Staff O was asked to check the temperature of the chicken breast prior to serving it, the temperature was 133 degrees which had not met the requirement of 165 degrees. Staff O then requested another chicken breast from the kitchen.</p> <p>Staff O had checked the temperatures of the cold items, the salad was 46 degrees, cottage cheese 41.5 degrees and the strawberries were 43.1 degrees. Cold foods needed to be less than 41 degrees. Staff O was going to serve the above foods after the temperatures had been obtained and were found to be to warm.</p> <p>In an interview on [DATE] at 12:31 PM, Staff O stated it was important to serve food at the appropriate temperature to prevent illness.</p> <p><Sanitary Practices></p> <p>During an observation of tray line on [DATE] at 11:57 AM, Staff O was plating food, turned toward the counter and rested their gloved hands on the surface, wearing the same gloves they opened the door of the heated cart, opened the refrigerator, got a sandwich, took the plastic wrap off the sandwich and grabbed the sandwich with the same unclean gloves and put it on the resident's plate.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>In an observation on [DATE] at 12:26 PM, Staff O was wearing gloves and had plated food. Staff O, wearing the same gloves, opened the refrigerator, grabbed a drink for a resident, and went back to plating food without performing hand hygiene or changing gloves. At 12:27 PM, Staff O wearing the same gloves, opened the refrigerator, took out a sandwich, picked it up and placed it on a plate, hand hygiene was not performed, and gloves were not changed.</p> <p>In an interview on [DATE] at 12:31 PM, Staff O stated they should have done hand hygiene after touching things and prior to touching the resident's sandwich and this was important to prevent the spread of germs.</p> <p>During an interview on [DATE] at 1:03 PM, Staff I stated hand hygiene should have been completed after touching things and prior to the food being served.</p> <p><Refrigerator temperatures></p> <p>In an observation on [DATE] at 11:20 AM, the refrigerator in the snack room had a [DATE] temperature log that hung on the refrigerator. The log stated the temperature was to be between 36 to 46 degrees, instructed staff to record the temperature and initial, and they needed to document what action had been taken if the temperature was out of range.</p> <p>The November log showed the temperature had been monitored 4 out of 15 days. The temperature was out of range on all four days and there was no documentation of what had been done to correct the out-of-range temperatures.</p> <p>In an interview on [DATE] at 1:03 PM, Staff I stated the kitchen aides were supposed to monitor the refrigerator temperatures and discard expired food. Staff I stated this was important, so the food did not go bad.</p> <p><Dishwasher temperatures></p> <p>During a second observation of the kitchen on [DATE], the dishwasher temperature log instructed staff to monitor the temperature in the morning, at noon and in the evening. The [DATE] log had four omissions in which the temperature was not monitored.</p> <p>A review of the [DATE] temperature log showed seven omissions, and the [DATE] log showed 22 omissions.</p> <p>In an interview on [DATE] at 1:01 PM, Staff I, Dietary Manager, stated it was important to monitor the dishwasher temperatures to ensure the dishes were sanitized and clean.</p> <p>Reference: WAC [DATE] (3), 2980</p> <p>47328</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>47328</p> <p>Based on observation and interview the facility failed to ensure standard precautions were maintained and hand hygiene was performed when indicated during 2 of 2 medication pass observations. This failure placed residents at risk of contracting communicable diseases and diminished quality of life.</p> <p>Findings included .</p> <p>Review of the facility policy titled, Hand Hygiene-Infection Prevention revised August 2024, showed hand hygiene was performed by using alcohol-based hand rub (ABHR) or washing hands with soap and water when visibly soiled or when contact with suspected infectious stools. The policy further showed staff should perform hand hygiene before and after contact with a resident, after contact with blood, body fluids, visibly contaminated surfaces, after contact with objects in the residents rooms, after removing personal protective equipment (PPE, gloves, gown, face mask), and before meals.</p> <p>The Centers for Disease Control and Prevention website, CDC.gov - with regard to standard precautions showed, standard precautions are based on the principle that all blood, body fluids, secretions, excretions except sweat, nonintact skin, and mucous membranes may contain transmissible infectious agents. Standard precautions include a group of infection prevention practices that apply to all patients, regardless of suspected or confirmed infection status, in any setting in which healthcare is delivered. These include: hand hygiene, use of gloves, gown, masks, eye protection, or face shield, depending on the anticipated exposure.</p> <p><200 Hall></p> <p>During observation on 11/15/2024 at 6:28 AM, Staff N, Licensed Practical Nurse (LPN), did not perform hand hygiene and dispensed medications for Resident 4. Staff N entered Resident 4's room without performing hand hygiene, touched the bed, bedside table, and administered medications to Resident 4. Staff N used ABHR when exiting the room.</p> <p>During observation on 11/15/2024 at 6:39 AM, Staff N, LPN, did not perform hand hygiene and dispensed medications for Resident 3. Staff N entered Resident 3's room washed their hands with soap and water prior to applying a pair of gloves. Staff N obtained a drop of blood to check Resident 3's blood sugar, without changing gloves or performing hand hygiene, Staff N administered an injection.</p> <p>In an interview on 11/16/2024 at 12:24 PM, Staff N, stated hand hygiene was cleansing hands with ABHR or washing with soap and water. Staff N stated hand hygiene was to be performed before and after resident care. Staff N explained staff should perform hand hygiene when indicated to prevent the spread of bacteria and potential infection.</p> <p>In an interview on 11/16/2024 at 12:34 PM, Staff C, Resident Care Manager, explained hand hygiene should be performed by using ABHR or washing with soap and water at various times including between residents and after glove removal. Staff C acknowledged gloves should be changed and hand hygiene performed between residents. Staff C expected staff to perform hand hygiene when indicated because it was the number one way of preventing infection.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 11/16/2024 at 3:31 PM, Staff B, Director of Nursing, explained hand hygiene should be performed at various times including before applying gloves and after glove removal. Staff B stated they expected staff to perform hand hygiene when indicated.</p> <p>46115</p> <p><100 Hall></p> <p>During an observation on 11/15/2024 at 8:17 AM, Staff G, Registered Nurse, administered an insulin injection into Resident 36's abdomen. The abdomen was not cleansed with an alcohol wipe prior to the injection and gloves were not worn.</p> <p>During an interview on 11/15/2024 at 8:25 AM, Staff G stated they should have worn gloves and cleansed the resident's abdomen prior to the injection, and this was important for infection control.</p> <p>In an interview on 11/16/2024 at 4:10 PM, Staff B, Director of Nursing, stated the expectation was for nursing to have cleansed the injection site prior to administration and to have worn gloves.</p> <p>Reference WAC 388-97-1320 (1)(c)</p>

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep all essential equipment working safely.</p> <p>46115</p> <p>Based on observation and interview, the facility failed to maintain kitchen equipment in a safe and clean operating condition for 1 of 1 stove hoods when reviewed. This failure placed staff at risk of injury, residents at risk of consuming contaminated food products and a diminished quality of life.</p> <p>Findings included .</p> <p>In the initial observation of the kitchen on 11/12/2024 at 12:05 PM, a section of the hood of the stove was falling and had an approximately four-inch gap from the hood to the ceiling. The stove hood had grease built up all along the edge of the opening.</p> <p>During a second tour of the kitchen on 11/15/2024 at 12:39 PM, the stove hood remained unchanged from the initial tour of the kitchen.</p> <p>In an interview and observation of the stove hood on 11/15/2024 at 1:01 PM, Staff I, Dietary Manager, stated the stove hood should have been closed and was cleaned quarterly in the past and was now cleaned twice a year. Staff I stated they had not been told about the stove hood hanging down and maintenance should have been notified.</p> <p>During an interview on 11/16/2024 at 1:27 PM, Staff J, Maintenance Assistant, stated they were notified about the stove hood on 11/15/2024. Staff J stated staff notified maintenance of needed repairs by calling a work request line and the expectation was that they be notified as soon as possible. Staff J added they thought this possibly happened when the stove hood was cleaned in October.</p> <p>Reference: WAC 388-97-2100</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47328</p> <p>Based on observation and interview the facility failed to ensure damaged paint and drywall was repaired timely after a water leak in 1 of 3 halls, reviewed for environment. In addition, the facility failed to ensure hazardous chemicals were secured in 1 shower room. This failure placed residents at risk of potentially avoidable accidents, lack of dignity and diminished quality of life.</p> <p>Findings included .</p> <p><Shower Rooms></p> <p>During an observation on 11/12/2024 at 1:42 PM, the shower room on the east hall was unlocked. The shower room had an unlocked cabinet that was at eye level. The cabinet contained two bottles of disinfectant cleansers that said to keep out of reach of children. A similar observation was made at 3:37 PM, the same day. There were no residents wandering or near the area.</p> <p>In an interview on 11/12/2024 at 4:04 PM, Staff K, Nursing Assistant, stated the cabinets were supposed to be locked. Staff K was shown the unlocked cabinets in the shower room and acknowledged the cleaning solutions should have been locked up. Staff K added they had never seen a resident come into the shower room unattended.</p> <p>During an interview on 11/12/2024 at 4:08 PM, Staff L, Registered Nurse, stated all chemicals were kept locked up because they are toxic and would be harmful to the residents.</p> <p>In an interview on 11/12/2024 at 4:09 PM, Staff B, Director of Nursing, confirmed the chemicals should have been locked up and this was important because cognitively impaired residents could ingest them.</p> <p><Paint and Drywall></p> <p>During observation on 11/15/2024 at 5:37 AM, a large section of ceiling and wall near the two dining rooms had large pockets of puffed-up paint going down the wall. When touched, the paint was filled with air pockets.</p> <p>During observation on 11/15/2024 at 5:43 AM, the ceiling in the hall between the two dining rooms had a large area of sagging drywall in the center of the hall. A section of ceiling above a light fixture and an electrical outlet had a large section of uneven bumpy drywall with dried brown discolored drip streaks going down the wall. The wallpaper at the bottom of wall near the floor was bubbled up and wrinkled, the trim along the bottom was not flush against the wall or floor tiles.</p> <p>During observation on 11/15/2024 at 5:52 AM, a large section of sagging drywall with a holes at the base were noted in the ceiling outside room [ROOM NUMBER].</p> <p>(continued on next page)</p>		

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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 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During observation and interview on 11/16/2024 at 12:24 PM, the various sections of drywall and paint damage were observed with Staff N, Licensed Practical Nurse. Staff N acknowledged it appeared as if the paint and drywall damage were a result of a water leak and was unsure how long the wall and/or drywall were in disrepair.</p> <p>During observation and interview on 11/16/2024 at 12:33 PM, the various sections of drywall and paint damage were observed with Staff G, Registered Nurse. Staff G was unsure how long the wall and/or drywall were in disrepair and informed maintenance.</p> <p>In an interview on 11/16/2024 at 1:24 PM, the various sections of drywall and paint damage were observed with Staff J, Maintenance Assistant. Staff J acknowledged there was a water leak over a year ago that resulted in the discolored brown streaks down the wall, sagging ceiling drywall damage, and bubbled up paint down the walls but the damage still had not been repaired.</p> <p>In an interview on 11/16/2024 at 5:04 PM, Staff B, Director of Nursing, acknowledged paint and drywall damage repairs from the water leak over a year ago, were not completed timely.</p> <p>Reference: WAC 388-97-3220 (1)</p> <p>46115</p>