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	02/28/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to follow food code regulations to prevent the potential of foodborne illness by not correctly performing hand hygiene when indicated during the lunch meal service for 2 of 2 dietary staff (Staff D and E). This failure placed residents at risk for food-borne illnesses.Findings included.On 02/26/2026 from 11:28 AM to 12:12 PM, dietary staff were observed preparing plates of food for the resident's lunch. Staff D, Dietary Aide, plated the main dish with utensils, while wearing gloves. Staff D was observed unlatching and opening the door of the heated food cart twice and opened the cooler door to remove needed items. Staff D did not change gloves, wash their hands or use hand sanitizer after touching the handles and resumed plating the food with the same gloves. Staff E, Cook, was observed placing slices of cheesecake on a plate, adding caramel drizzle and apple topping. Staff E touched the handle of the cooler, removed items from the cooler, then touched the cheesecake (to nudge it to the center of the plate) and squeezed the caramel bottle while wearing the same gloves. Staff E changed gloves during food service, but they did not do hand hygiene with the glove changes. Neither Staff D or Staff E washed their hands at the sink until the food service was completed or used hand sanitizer during any of the glove changes, as required.During an interview on 02/26/2026 at 12:12 PM, Staff E stated they should change gloves after touching anything other than the serving utensils. Staff D agreed and said they should have changed gloves after touching the cooler handles. When asked if they needed to wash hands or use hand sanitizer at any time, they both stated that they should have done so whenever they changed gloves.During an interview on 02/27/2026 at 2:55 PM, Staff C, Registered Dietician, stated they expected dietary staff to perform hand hygiene (either wash hands or use hand sanitizer) with every glove change, and they should change gloves after touching other surfaces during meal preparation.Reference: WAC 388-97-1100(3), 2980

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505454	A. Building B. Wing	02/28/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure pharmacy recommendations were followed up on for 1 of 5 sampled residents (Resident 3), reviewed for unnecessary medication. This failure placed the resident at risk for experiencing adverse side effects from receiving medication at a higher dose, and for being on a medication for a longer duration than medically necessary. Findings included. <Resident 3> Review of the annual assessment dated [DATE], documented Resident 3 had diagnoses which included Parkinson's disease, a progressive brain disorder that caused problems with movement, balance, and coordination. Review of the Order Summary Report, dated 05/16/2023, showed that Resident 3 was prescribed Carbidopa-Levodopa, a medication used to treat the symptoms of Parkinson's disease. Review of the Pharmacy consultation Report, completed on 09/29/2025, documented Resident 3 received Carbidopa-Levodopa during flexible medication times, a window of time when medications were administered. The report stated in order to provide better management of the symptoms, it was recommended the medication be administered at specific times and not flexible medication times. Review of the Medication Administration Records (MAR) showed the months of October 2025 and November 2025 documented the Carbidopa-Levodopa continued to be administered during flexible medication times. No documentation was found in the resident's record to show the physician had been informed of the 09/29/2025 pharmacy recommendations. The 11/24/2025 Pharmacy Consultation Report repeated the 09/29/2025 recommendation to have the Carbidopa-Levodopa changed to a specific administration time. Review of the December 2025 MAR showed on 12/26/2025, the administration time for the Carbidopa-Levodopa had been changed to a specified time, almost three months after the initial pharmacy recommendation. In an interview on 02/27/2026 at 10:27 AM, Staff B, Resident Care Manager, stated the facility had identified some issues with timely follow-up with regard to the pharmacy recommendations. Reference (WAC) 388-97-1300(4)(c)