STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505454	A. BUILDING _____ B. WING _____	03/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure five of five sample residents (#1,2,3,4,5), reviewed for nutrition, received care and services to identify, implement, monitor, and modify interventions that were consistent with the resident's assessed needs and goals. These failures placed the residents at risk for weight loss and poor nutrition. Findings included . A facility policy, titled, Order Writing Privileges for Dietitians, dated 06/2019, showed the Registered Dietitian Nutritionist was delegated the task of ordering and modifying diets, ordering nutritional supplements, and making weight management plans, in accordance with each resident's needs, as determined by the nutritional assessment process. In addition, the Registered Dietician was to complete each resident's nutritional assessment or reassessment according to the MDS (Minimum Data Set - a required standardized tool, to screen and assess the health status of residents, to develop a person-centered plan of care) at scheduled intervals, and as needed. 1. According to the annual assessment, dated 12/16/19, Resident #1 had [DIAGNOSES REDACTED]. The assessment further showed she was moderately impaired in memory, required supervision and set-up for eating, and had no weight loss. The nutritional risk assessment, dated 12/19/19 (three days after the MDS data was to have been completed), showed inconsistent data. The resident's significant and relevant medications related to her depression and skin issues were not listed. The physician ordered diet was listed as regular, low concentrated sweets, however, the nutritional assessment showed she was to have cut-up/minced food (and a diabetic diet was not listed). A significant portion of the assessment was blank. The assessment showed the resident ate greater than 75% of her meals, but continued to have slow weight loss. The only interventions listed were additional blood testing and an increase in her vitamins. Staff C, Registered Dietician, had marked the resident as both low risk and medium risk of nutritional impairment, without providing a summary as to why. In an observation on 03/04/2020 at 7:45 AM, Resident #1 was seated at the dining table having breakfast. She was served a regular meal, and was able to eat it independently. In an interview on 03/04/2020 at 8:15 AM, Staff B, Resident Care Manager, stated that Resident #1 has had significant weight loss and severe depression. According to the weight record, the resident weighed 221.6 pounds on 09/06/19, and her current weight was listed as 178.1 pounds - or a 19.6% weight loss in six months. Staff B felt that her antidepressant was causing the lack of hunger, and her medications were changed. The record showed after that time, the resident had gained two pounds. Staff B further stated that they felt the weight loss was unpreventable (as she recently had a mild stroke) and therefore, the resident was placed on comfort measures only, per the guardian. A review of the dietary progress notes from 01/03/2020 through 03/04/2020 did not show any follow-up documentation by Staff C, regarding the resident's weight loss. 2. According to the quarterly assessment, dated 01/19/2020, Resident #2 had [DIAGNOSES REDACTED]. The assessment further showed she was cognitively intact for daily decision-making, was independent with eating, had difficulty swallowing when eating, and had no weight loss. A nutritional assessment, dated 01/22/2020, showed the assessment was still pending and therefore, had not been completed (six weeks after the MDS data was to be completed). The assessment showed the resident was both low risk and high risk for nutritional impairment, with no additional explanation. The only interventions listed on the assessment were blood work and an increase in her vitamins. The weight record showed on 09/13/19, Resident #2 weighed 212.5 pounds, and per the record, her current weight was 204.7 pounds - a 3.67% weight loss in six months (which is not considered significant weight loss). A review of the dietary progress notes did not show any further follow-up documentation by Staff C after 01/15/2020, related to the weight loss, or additional measures to put in place. 3. According to the quarterly assessment, dated 02/23/2020, Resident #3 had [DIAGNOSES REDACTED]. The assessment further showed the resident was moderately impaired in memory, had no swallowing problems, and no significant weight loss or gain. The nutritional risk assessment, dated 02/28/2020 (five days after the MDS was to have been completed), showed the resident was identified as both low risk and medium risk for nutritional impairment, with no additional explanation. In addition, the assessment did not list the relevant and significant medication the resident was prescribed. Staff C indicated that the resident had no teeth, but had significant weight gain over 6 months, and that she would continue her diet of high fortified foods (high calorie dense food such as butter and gravy), despite the resident's weight gain. A 02/28/2020 care conference note showed the same information as the nutritional assessment, and no new interventions or plans to follow-up were identified, despite the resident being 23.8 pounds above her ideal body weight. 4. According to the annual assessment, dated 12/30/19, Resident #4 had [DIAGNOSES REDACTED]. The assessment further showed she was severely impaired in cognition, required extensive assistance for eating, had no swallowing problems, and no significant weight loss or gain. The nutritional risk assessment was done by Staff C, Registered Dietician, on 10/09/19 (11 weeks prior to the quarterly assessment), which showed the resident was moderately at risk for nutritional impairment. The record did not show any other dietary progress notes or assessment had been documented as completed, from 10/09/19 through 03/04/2020. 5. According to the quarterly assessment, dated 02/14/2020, Resident #5 had [DIAGNOSES REDACTED]. The assessment showed that he was cognitively intact for daily decision-making, had no swallowing disorders, and had no significant weight loss or gain. A 02/04/2020 care conference dietary note showed that the resident had presented with significant weight gain over one week; whether it was food or fluid related was unknown. The written goal was to maintain his current weight without significant weight changes, for 90 days. The record showed that the most recent nutritional assessment was completed on 11/13/19. There was no documentation of a nutritional assessment within the seven day observation period, prior to the February 2020 quarterly MDS assessment. The November 2019 assessment showed the resident was at high risk for impaired nutrition. A nutrition care plan, dated 12/02/19, showed the resident had potential nutritional problems of obesity, elevated blood sugars (due to diabetes), and multiple pressure ulcers, upon admission. The care plan also showed the resident had no upper teeth, and refused to wear dentures. His weight was listed on 11/13/19 at 248.3 pounds, and per the record, his current weight was 232.5 pounds. The care plan further showed the resident was on a fluid restriction of 1800 milliliters in 24 hours. In an interview on 03/04/2020 at 2:37 PM, Resident #5 was observed seated in his wheelchair, coming from the activity room. He was alert and oriented with clear speech. He was asked about his weight fluctuations, confirmed his weight had been up and down, and that he had been on a fluid restriction, but was now off it, as he had passed. He further stated that he had lost about 20 pounds. He was asked if he had seen the dietician to discuss his variable weights. He stated he thought so, but was not sure. In an interview on 03/04/2020 at 12:00 PM, Staff A, Director of Nursing and Staff B, Resident Care Manager stated the resident had stopped snacking, but the interventions from the dietician were not reflected in the care plan, and this had been a problem. Per Staff A and Staff B, a lot of the interventions were not person-centered, and that nursing had been trying to fix the care plans to be more reflective, but it had been hard. In an interview on 03/04/2020 at 3:00 PM, Staff C was asked about the missing nutritional assessments, as well as several dietary progress notes. She stated she had been having computer issues and had no idea were they were, but that she did them (no new documentation was provided). Staff C stated that she attended the weekly weight meeting however, the documentation was done by nursing. Staff C was asked if she watched meals, to see if residents were served their prefererred food, or how much they ate of a meal, to see if a texture change, or additional intervention was

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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F 0692 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) warranted. She stated no. Reference: (WAC) 388-97-1060 (3)(h)