STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505059	A. Building B. Wing	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Panorama City Conv & Rehab Ctr	1600 Sleater Kinney Road SE Lacey, WA 98503

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on interview, and record review, the facility failed to ensure services provided met professional standards of practice when physician orders were not followed and the provider was not notified when medications were held for 1 of 5 sampled residents (Resident 40) reviewed for unnecessary medications. This failure placed residents at risk for medication errors, adverse side effects, delayed review of their medication regimen and unmet care needs. Findings included . Resident 40 was admitted to the facility on [DATE]. Review of their physician orders showed an 08/26/2023 order for Metoprolol (a blood pressure medication) twice daily for high blood pressure, with direction to hold the medication for a systolic blood pressure (SBP) less than 110 or a pulse (P) less than 60. Review of the September 2024 Medication Administration Record (MAR) showed facility nurses administered Resident 40's Metoprolol outside of the physician's ordered parameters on the following occasions: a) 09/22/2024 at 8:00 AM- P=50; medication was administered. b) 09/05/2024 at 8:00 AM- P=55; medication was administered. c) 09/10/2024 at 8:00 AM- P=59; medication was administered. d) 09/20/2024 at 8:00 PM- SBP=109; medication was administered. On 10/16/2024 at 2:12 PM, Staff L, Unit Manager, said facility nurses administered Resident 40's Metoprolol outside of the physician ordered parameters, and it was the expectation that nurses administered medication in accordance with physician's orders. The September 2024 MAR showed Resident 40's Metoprolol was held eight times for a SBP less than 110 or a P less than 60. (continued on next page)

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The September 2024 MAR showed the resident had a 03/07/2022 order for Imdur (an antianginal medication, treats chest pain by relaxing/widening blood vessels), twice daily, with direction to hold for a SBP less than 110. The MAR showed facility nurses held the medication eight times in September 2024. Review of Resident 40's electronic health record did not show documentation the provider was informed of the held medications. On 10/16/2024 at 2:17 PM, Staff L said nurses should notify the provider when they hold medications. Documentation was requested showing the 16 above referenced occasions, in which the resident's Imdur and Metoprolol were each held on eight occasions in September 2024. No further documentation was provided. Reference WAC 388-97-1620(2)(b)(i)(ii)

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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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46793 Based on observation, interview and record review, the facility failed to ensure intravenous (IV) access devices were assessed, maintained and monitored in accordance with professional standards of practice when IV orders did not include routine monitoring of IV insertion sites, weekly changes of IV dressings and needleless injection caps and an initial and then weekly measurements of IV catheters external length and the resident's arm circumferences for 1 of 1 sampled residents (Resident 74) reviewed for IV therapy. This failure placed residents at risk for loss of vascular access, infection, and other potential negative health outcomes. Findings included . The facility policy entitled Midline Catheter Dressing Change, revised June 2024, documented Guidance 1. Sterile dressing change using transparent dressing is performed: 1.1 Upon admission 1.1.1 If transparent dressing is dated, clean dry and intact the admission dressing change may be omitted and scheduled for 7 days from the dated on the dressing label 1.1.1.1 Upper arm circumference and external catheter length measurements must still be completed as part of the initial assessment. 1.2 At least weekly 2 1.3 If the integrity of the dressing has been compromised (wet, loose, or soiled). Resident 74 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS, an assessment tool) documented Resident 74 was cognitively intact. The Midline Insertion Record, dated 10/03/2024, documented the Int (Internal) length (tubing) 10 centimeters (cm) and no external length. Resident 74's Comprehensive Care Plan showed no documentation pertaining to the Midline IV including maintenance and/or monitoring of the IV access site. On 10/10/2024 at 10:21 AM, Resident 74 said the Midline IV had been placed in the right arm after determining they were positive for an infection and required IV antibiotics. Resident 74 said the IV (transparent) bandage had not been changed since it was inserted. Observation of the transparent bandage showed no date for when the bandage was received. Dried blood was observed at the insertion site and along both sides of the IV tubing, under the transparent dressing. The October 2024 Medication and Treatment Administration Records (MAR/TAR) showed there was no documentation the facility staff had: (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a) Monitored the IV insertion site for signs and symptoms of infection or infiltration. b) Performed weekly midline dressing changes. c) Measured the midline external length weekly. d) Measured the resident's right arm circumference weekly. On 10/15/2024 at 2:19 PM, Staff D, Unit Manager, said care and maintenance of a Midline IV included every shift, looking at the insertion site and the dressing, making sure there were no signs or symptoms of infection, and looking at the skin for damage or bruising. Every shift should be flushing the IV with saline as per ordered. When asked about measurements, Staff D said staff should be measuring the external length of the tubing to assure the tubing is not being pulled out. After reviewing the Midline Insertion Record, dated 10/03/2024, in the electronic health record (EHR), Staff D said there was no external length on the report, therefore staff would not know what to measure. Staff D said the missing length should have been caught and she could not show where staff had been documenting the external length. Staff D said needleless injection caps were changed on any blood draw and when the tubing was changed. When asked about the observation of the soiled bandage, Staff D said Resident 74 was having issues with bleeding and the bandage should have been changed. At 2:53 PM, Staff B, Director of Nursing Services, said the expectation for maintenance and monitoring for Midline IV's was for staff to be following doctor's order (flushes), checking the site for signs and symptoms of infection, and changing dressings as required. Staff B said this should be done daily. After reviewing Resident 74's EHR, Staff B said he could not locate where the external measurement documentation was. Staff B said the external measurements should be documented. Staff B said he could not locate information regarding if the needleless injection caps had been changed. When asked about the observation of the soiled bandage, Staff B said if the integrity of the bandage was compromised, then the bandage should have been changed. Reference WAC 338-97-1060 (3)(j)(ii)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46793 Based on interview and record review, the facility failed to ensure person centered side effect and target behavior monitoring was identified for psychotropic medications (drug taken to exert an effect on the chemical makeup of the brain and nervous system) for 4 of 5 sampled residents (Resident 74, 46, 42 & 3) reviewed for unnecessary psychotropic medications. This failure placed residents at risk for receiving unnecessary medications, adverse side effects, falls, injury and a diminished quality of life. Findings included . The facility policy entitled Psychoactive Medication, revised 04/07/2024, documented, POLICY: Specific behaviors are identified for each resident that affect the resident's quality of life. 9. Side effects must be listed on the Medication Treatment Record (TAR) for each group of medications. Side effects are documented daily on the MAR . 10. Care Pal must be developed around the behaviors the resident is currently exhibiting. Identify only the behaviors that can realistically be changed and includes possible causes for these behaviors. Interventions should be specific for each behavior. 15. The Monthly Behavior Monitoring POC [Point of Care] must be instituted for each resident receiving anti-psychotic or anti-anxiety. POC should identify the specific behaviors the psychoactive medication is prescribed for. 1) Resident 74 was admitted to the facility on [DATE] with diagnoses including depression (a mental health condition that involves a prolonged low mood or loss of interest in activities). The Quarterly Minimum Data Set (MDS, an assessment tool) documented Resident 74 was cognitively intact and prescribed an anti-depressant medication. Resident 74's electronic health record (EHR) did not show Resident 74 had person-centered side effect or target behavior monitoring for the anti-depressant medication. On 10/15/2024 at 2:19 PM, Staff D, Unit Manager, said before administering any psychotropic medication, a physician's order, consent, an assessment (completed by Social Services), and side effect and target behavior monitoring were required. When asked about the side effect and target behavior monitoring for Resident 74, Staff D said she could not find any. Staff D said Resident 74 should have side effect and target behavior monitoring. At 2:53 PM, Staff B, Director of Nursing Services, said consent, diagnosis, an assessment, non pharmological interventions and orders should all be in place before administering a psychotropic medication. When asked about side effect and target behavior monitoring for Resident 74, Staff B said Resident 74 should have had side effect and target behavior monitoring. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/16/2024 at 12:21 PM, Staff E, Social Services, said the facility had a tracking system for all residents on a psychotropic medication. After opening Resident 74's electronic health record (EHR) and showing a list of Patient Health Questionnaire-9 (PHQ-9, a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression) questions, Staff E said all resident have this questionnaire. When asked where this document generated from, Staff E stated, I don't know. After opening the mood tracking tab, Staff E said all residents have mood tracking too. When asked where the questions were pulled from, Staff E said the MDS. When asked to provide Resident 74's person centered side effect and target behavior monitoring for the anti-depressant, Staff E stated, I don't know if I would have any additional behavioral tracking for her. We don't have any for her. When asked if there should have been individualized side effect and target behavior monitoring for Resident 74's anti-depressant medication, Staff E said yes. 42960 2) Resident 42 was admitted to the facility on [DATE] with diagnoses including Major Depressive Disorder (a serious mood disorder that can affect how people feel, think, and behave) and dementia (a chronic condition that causes a decline in mental functioning, such as thinking, remembering, and reasoning, to the point that it interferes with daily life). The Quarterly MDS, dated [DATE], documented Resident 42 was severely cognitively impaired. Resident 42's physician orders listed orders for Venlafaxine (antidepressant) 75 mg[milligrams] by mouth Daily for Depression and Seroquel (antipsychotic) 25 mg by mouth at bedtime for distressing delusions [a belief that is clearly false and that indicates an abnormality in the affected person's content of thought] and aggressive behaviors toward others. Resident 42's Care plan listed a Behavior Category with specific behaviors exhibited yelling, agitation, and delusions/hallucinations. Resident 42's Daily Charting listed Mood - staff observations of Hallucinations (seeing, hearing, smelling, feeling something that is not there). On 10/16/2024 at 1:19 PM, Staff B said they expected there to be more specifics in the daily tracking, such as what was disturbing them and how it was affecting them. 50392 3) Resident 46 was admitted to the facility 05/27/2024 with diagnoses including depression and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, and fear). The Quarterly MDS, dated [DATE], documented Resident 46 was cognitively intact and was prescribed an anti-depressant. Resident 46's EHR documented Resident 46 did not have person-centered target behavior monitoring for the anti-depressant. 37044 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4) Resident 3 was admitted to the facility on [DATE]. Review of the Annual MDS, dated [DATE], showed the resident was moderately cognitively impaired, had diagnoses of non-Alzheimer's dementia and depression disorder, demonstrated verbal and physical behavioral symptoms towards others (e.g., hitting, kicking, scratching etc.) on one to three days during the assessment period, and received antipsychotic medication. Resident 3 physician's orders documented a 07/17/2024 order for Seroquel (an antipsychotic) three times a day for dementia with behavioral disturbances. A dementia with behaviors care plan, revised 07/28/2024, identified the target behaviors for the use of Seroquel as hallucinations, delusions or withdrawals. Review of Resident 3's EHR did not show documentation of Resident 3 experiencing hallucination, delusions or withdrawals. On 10/16/2024 at 10:34 AM, when asked if Resident 3 had ever had hallucination, delusions or withdrawals Staff M, Unit Manager, stated, No, not hallucinations or withdrawals; but the delusion would be her misguided belief that she can walk. When asked whether a dementia diagnosis with behaviors, with an identified target behavior of having a misguided belief they could walk was an adequate indication for use of an antipsychotic medication, Staff M said the reason Resident 3 was started on Seroquel was due to the resident demonstrating verbal and physical behaviors towards others, but said those were not identified as the targeted behaviors for the use of Seroquel. The October 2024 Treatment Administration Record (TAR) showed the target behaviors for the use of Seroquel were identified as: a) Declining staff care/medications; b) Being argumentative and making false statements towards staff when redirected regarding declining care. c) Being tearful and argumentative with husband; d) Fixed beliefs regarding her mobility capabilities. No non-pharmacological behavioral interventions were identified. The targeted behaviors were also resident rights (e.g. declining care and/or medications, filing complaints or allegations against staff, being argumentative with husband etc.). The TAR behavior monitoring did not identify verbal and physical behaviors towards others as a targeted behavior for the use of Seroquel. On 10/16//2024 at 10:41 AM, when asked if a resident had a right to decline care and/or medications, to file complaints, to make allegations against staff, or to be argumentative with their husband, Staff M stated, Yes. When asked if those were appropriate targeted behaviors for the use of an antipsychotic medication, Staff M said the reason the Seroquel was initiated was for verbal and physical behaviors towards others. Staff M said the care planned targeted behaviors for the use of Seroquel did not match the TAR targeted behaviors for the use of Seroquel; and neither included verbal/physical behaviors towards others as a targeted behavior. Review of the October 2024 TAR showed on 10/02/2024 and 10/03/2024 staff documented a + to indicate Resident 3 had demonstrated a targeted behavior for the use of Seroquel, but there was no indication which targeted behavior was demonstrated. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/16//2024 at 10:41 AM, when asked what targeted behavior Resident 3 demonstrated on 10/02/2024 and 10/03/2024, Staff M said they did not know because the charting did not identify what targeted behavior was demonstrated. Staff M indicated it was important to identify a resident's specific targeted behaviors that a psychotropic medication was initiated to treat, because staff monitor for increases or decreases in the frequency of the targeted behaviors to evaluate the effectiveness of the medication and need for continued use. Staff B said having different targeted behaviors identified on the care plan and TAR for the use of Seroquel, and neither one identifying verbal/physical behaviors towards others as the targeted behaviors detracted from the ability to effectively monitor the effectiveness of the medication and need for continued use. Reference WAC 388-97-1060 (3)(k)(i)

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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. 37044 Based on observation, interview and record review, the facility failed to ensure food products were labeled with a prepared or use by date, staff performed hand hygiene and glove changes during meal preparation and service, and that the high temperature (Hi-temp.) dishwasher washer met the minimum wash and rinse temperatures required for proper cleaning and sanitization of resident dishware and utensils. This failure placed residents at risk for food borne illnesses. Findings included . <Hi-Temperature Dishwasher Temperature Log> Observation of the facility's Hi-temp. dishwasher on 10/15/2024 at 7:39 AM, showed there was a laminated sign and a dishwasher temperature log where staff were to record the wash and rinse cycle temperatures of the dishwasher three times a day. The October 2024 dishwasher temperature log showed for proper sanitization of dishware/ utensils, the wash cycle must reach 150 - 160 degrees, and the rinse cycle needed to reach 180 degrees Fahrenheit (df). The log contained instruction to staff to PLEASE report temperatures out of the required range to your supervisor immediately. Review of the laminated instruction sheet attached to the front of the dishwasher, showed it provided staff the following direction !!!!!!PLEASE READ!!!!!! Read wash temp and rinse temp and record, with initials, every day. This is extremely important in complying with health code standards. Review of the facility's Hi-temp. dishwasher testing log on 10/15/2024 at 7:53 AM, showed staff recorded dishwasher rinse cycle temperatures that failed to meet the minimum required temperature of 180 df on the following dates: Breakfast Rinse Temperatures - 10/01/2024= 175 - 10/02/2024= 178 - 10/03/2024= 177 - 10/08/2024= 178 - 10/09/2024= 179 - 10/10/2024= 177 - 10/12/2024= 178 (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Lunch Rinse Temperatures - 10/01/2024= 178 On 10/15/2024 at 7:39 AM, Staff P, Dietary, said on the above referenced occasions, dietary staff recorded dishwasher rinse cycle temperatures below the minimum required rinse temperature of 180 degrees. Staff P said if the dishwasher wash or rinse cycles failed to meet the minimum required temperature, staff were to report it immediately to their supervisor, who in turn would inform the Sous Chef. Staff P said the Sous Chef was who contacted the vendor about any dishwasher issues/concerns. When asked if contact with the vendor was documented somewhere, Staff P said the vendor provided the facility with documentation of their communication. At 10:47 AM, when asked if there was any documentation showing staff notified their supervisor of the eight rinse cycle temperatures that failed to reach the minimum temperature of 180 degrees or otherwise took any action to address the issue, Staff P stated, No, I don't think so. No further documentation was provided. <100 Hall Oxygen Room Refrigerator> Observation of the resident refrigerator in the 100-hall oxygen room on 10/14/2024 at 11:26 AM, showed there was four undated and unlabeled containers filled with a red gelatin-like substance. On 10/15/2024 at 10:10 AM, Staff O, Dietary Manager, stated, Food prepared by the facility needs to be labeled with the date it was prepared, or a use by date. 46793 <1st Floor Dining Room Steam Table> On 10/09/2024 at 11:43 AM, Staff F, Dietary Aide, was observed touching food (beef pot pie) with gloves on, then proceeded to move around the kitchen area touching environmental surfaces (cupboards handles, countertop and food carts), looking for cookies. Staff F did not change his gloves before moving onto the next plate. At 11:45 AM, Staff F was observed touching food (beef pot pie) with gloves on. Staff F did not change the gloves before moving onto the next plate. At 11:46 AM, Staff F was observed touching food (beef pot pie) with gloves on. Staff F did not change the gloves before moving onto the next plate. At 11:47 AM, Staff F was observed touching food (beef pot pie) with gloves on Staff F did not change the gloves before moving onto the next plate. At 11:49 AM, Staff F was observed touching food (crab patty) with gloves on. Staff F did not change the gloves before moving onto the next plate. At 11:50 AM, Staff F was observed touching food (beef pot pie) with gloves on. Staff F did not change the gloves before moving onto the next plate. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 11:52 AM, Staff F was observed touching food (crab patty) with gloves on. Staff F did not change the gloves before moving onto the next plate. At 11:54 AM, Staff F was observed touching food (crab patty) with gloves on. Staff F did not change the gloves before moving onto the next plate. At 11:55 AM, Staff F was observed touching food (crab patty) with gloves on. Staff F did not change the gloves before moving onto the next plate. At 11:55 AM, Staff F was observed touching food (crab patty) with gloves on. Staff F did not change the gloves before moving onto the next plate. At 11:56 AM, Staff F was observed touching food (crab patty) with gloves on. Staff F did not change the gloves before moving onto the next plate. At 11:57 AM, Staff F was observed leaving the dining room with a food cart and gloves on. At 12:00 PM, Staff F was observed returning to the kitchen no longer wearing gloves. Staff F donned new gloves without washing hands. At 12:03 PM, Staff F was observed touching food (crab patty) with gloves on. Staff F did not change the gloves before moving onto the next plate. At 12:05 PM, Staff F was observed touching food (beef pot pie) with gloves on. Staff F did not change the gloves before moving onto the next plate. At 12:06 PM, Staff F was observed touching food (crab patty) with gloves on. Staff F did not change the gloves before moving onto the next plate. At 12:06 PM, Staff F was observed touching food (crab patty) with gloves on. Staff F did not change the gloves before moving onto the next plate. At 12:08 PM, Staff F was observed touching food (crab patty) with gloves on. Staff F did not change the gloves before moving onto the next plate. At 12:08 PM, Staff F was observed touching food (crab patty) with gloves on. Staff F did not change the gloves before moving onto the next plate. At 12:09 PM, Staff F was observed touching food (crab patty) with gloves on. Staff F did not change the gloves before moving onto the next plate. At 12:10 PM, Staff F was observed wiping his gloves on his apron. At 12:11 PM, Staff F was observed changing his gloves and did not complete hand hygiene. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 12:25 PM, when asked when should hand hygiene/changing gloves be completed, Staff F said before temping food and taking off your gloves. When asked what measures were in place to prevent cross contamination of food, Staff F said using different utensils and checking the food tickets for allergies. When asked if touching food was acceptable, Staff F said no. After reviewing the documented times Staff F had touched the food, Staff F stated, I didn't realize I was touching the food. It must have been subconsciously. When asked if he should have been touching the food, Staff F said no. Reference WAC 388-97-1100(3); -2980

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Panorama City Conv & Rehab Ctr	1600 Sleater Kinney Road SE Lacey, WA 98503

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50392 Based on observation and interview, the facility failed to ensure appropriate hand hygiene was used during dining tray pass for 1 of 3 sampled rooms (room [ROOM NUMBER]) reviewed for dining and 1 of 2 sampled residents (Resident 74) reviewed for transmission based precautions. This failure placed residents at risk for facility acquired or healthcare associated infections and related complications and a diminished quality of life. Findings included . <Dining> On 10/09/2024 at 11:46 AM, Staff H, Certified Nursing Assistant (CNA), was observed passing a food tray to an unknown Resident in room [ROOM NUMBER]. Staff H knocked on the door of room [ROOM NUMBER] and put the food tray down on the bedside table, then assisted placing a shirt saver (garment to protect clothing from food spills) on an unknown resident, touching resident clothing in the process. No hand hygiene was observed after placement of shirt saver and before exiting room and getting a new tray for the next resident. At 11:50 AM, Staff H said she washed her hands at the beginning of tray pass and if she got a resident out of bed, but not when setting up trays. At 12:30 PM, Staff B, Director of Nursing Services, said if staff were touching residents or their food, they should be performing hand hygiene after contact. Staff should wash their hands with soap and water. <Transmission Based Precautions> On 10/16/2024 at 11:27 AM, Staff G, CNA, was observed providing care to Resident 74. Staff G was wearing gloves during care and once gloves became soiled, she removed soiled gloves and took new gloves out of a box of gloves and put them on. No hand hygiene was observed between glove changes. At 11:45 AM, after providing additional care to Resident 74, Staff G removed soiled gloves and took new gloves out of a box of gloves and put them on. No hand hygiene was observed between glove changes. At 12:00 PM, Staff D, Unit Manager, said when gloves were soiled, staff should take off soiled gloves and perform hand hygiene before putting clean gloves on. Reference WAC 388-97-1320 (1)(c)