STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505154	A. Building B. Wing	06/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tacoma Nursing and Rehabilitation Center	2102 South 96th Street Tacoma, WA 98444

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to use measured spoons when serving and provide foods listed on the menu for 2 of 2 sampled days (06/17/2026 and 06/22/2026) reviewed for kitchen. This failure placed residents at risk of receiving reduced portions, receiving inadequate nutrition, avoidable weight loss, and a diminished quality of life. Findings included.Observation on 06/17/2026 at 11:33 AM showed Staff M, Dietary Manager, was serving rice with a gray handled scoop, vegetable medley with a green handled scoop, and carrots (the alternative to the vegetable medley) with an unmeasured silver slotted spoon. Review of the menu for 06/17/2026 lunch showed a half cup of vegetable medley, a half cup of rice, and did not show carrots included as an alternate. Review showed that residents with soft and bite size, minced, and pureed diets received altered rice. Review showed chocolate cake with peanut butter was to be served for dessert. Observation on 06/17/2026 at 12:29 PM showed the facility served cinnamon apples (the previous day's lunch dessert) for dessert. Observation and interview on 06/17/2026 at 12:32 PM showed there was no rice prepared for residents with soft and bite size, minced, and pureed diets. Staff M, Dietary Manager, stated residents with soft and bite size, minced, and pureed diets were served mashed potatoes instead of rice. Review of the menu for 06/22/2026 lunch showed teriyaki pot roast, snap peas, steamed rice, dinner roll, and peach short cake was to be served. Observation on 06/22/2026 at 11:49 AM showed the rice and snap peas were being served using unmeasured silver slotted spoons. During an interview on 06/22/2026 at 11:50 AM, Staff M, Dietary Manager, stated unmeasured silver slotted spoons were being used to serve rice and snap peas. Staff M stated no altered texture rice was prepared and mashed potatoes were being served in its place. Observation on 06/22/2026 at 11:57 AM showed facility staff prepared an order of two cheeseburgers that used slices of white bread in lieu of hamburger buns. During an interview on 06/22/2026 at 12:46 PM, Staff M, Dietary Manager, stated the facility ensured portion sizes were correct by using measured scoops when serving, and the unmeasured silver slotted spoons were for cooking. Staff M stated the menu would specify the correct amount to be provided. Staff M stated the facility did not follow the menu when it specified altered textured rice and instead would provide mashed potatoes. During an interview on 06/22/2026 at 1:57 PM, Staff A, Administrator, stated kitchen staff ensured portions sizes were correct by following the menu specified portions and using measured spoons and the observations of staff using unmeasured or incorrect measured spoons did not meet expectations. Reference WAC 388-97-1160(1)(a)(b), -1120(3)(c)(4)

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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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 ensure food was safely stored and prepared and dishes were sanitarily washed when reviewed for kitchen. This failure placed residents at risk of consuming contaminated foods, foodborne illness, a decline in condition, and a diminished quality of life. Findings included.Observation on 06/16/2026 at 8:57 AM showed the dry storage area had a canned food rack with one dented can of mandarin oranges and two dented cans of apples. Observation on 06/16/2026 at 9:01 AM showed the kitchen handwashing sink had a trash can with a lid that was not operatable via foot. Observation showed the lid needed to be lifted by hand to dispose of used paper towels. Observation on 06/17/2026 at 11:17 AM showed the facility's walk-in freezer showed 10 degrees Fahrenheit (F) and freezer items such as small single serve ice cream and hot dogs buns were soft to the touch and not frozen. Observation on 06/17/2026 at 11:20 AM showed Staff M, Dietary Manager, completed hand hygiene and carried a used paper towel across to the kitchen to a trash can with a hole in the top near the tray line. Observation on 06/17/2026 at 11:24 AM showed Staff O, Dietary Aid, completed hand hygiene and carried a used paper towel across to the kitchen to a trash can with a hole in the top near a prep station. Observation showed the trash can was overflowing, the lid could not sit flush with the can, and trash was sitting on top of the trash can. Observation on 06/17/2026 at 11:26 showed the washing machine's drain became clogged causing a large puddle in the dishwashing area. Observation showed a pack of cigarettes floating in the puddle and Staff N, Dishwasher, picked up the cigarettes from the puddle with gloved hands, opened to check the cigarettes, and put them aside. Observation showed Staff N returned to loading dirty dishes, moved to the clean dish area and began unloading clean dishes, and did not perform a glove change at any point. Observation on 06/17/2026 at 11:28 AM showed the overflowing trash can near the prep station contained used paper towels, gloves, and an empty, dented can which showed it had previously contained apples. Observation showed a dented can of apples next to the industrial can opener on the prep station. Observation on 06/17/2026 at 11:35 AM showed Staff M, Dietary Manager, performed hand hygiene and walked the used paper towel across the kitchen to a trash can with a hole in the lid near the tray line. Observation on 06/17/2026 at 11:36 AM showed Staff N, Dishwasher, unload a dietary cart of dirty dishes, pushed the cart across the kitchen into the back, took a rag from a sanitation bucket and wiped down the cart, returned to the dishwashing area, and unloaded clean dishes from racks without performing a gloves change at any point. Observation on 06/17/2026 at 11:45 AM showed Staff N, Dishwasher, sprayed and loaded dirty dishes and moved to unload clean dishes into the plate warmer without performing a glove change. Observation on 06/17/2026 at 11:48 AM showed Staff O, Dietary Aid, performed hand hygiene and moved across the kitchen to throw the used paper towel into the overflowing trash can, which laid on top of the garbage on top of the lid. Observation on 06/17/2026 at 11:48 AM showed Staff N, Dishwasher, loaded dirty dishes, moved to unload clean dishes, handed a tray of cups to another staff, and unloaded clean silverware without performing a glove change. Observation on 06/17/2026 at 11:49 AM showed a nursing staff bring a lunch tray back to the kitchen for replacement as it contained rice, which the resident did not like. Observation showed Staff O, Dietary Aid, took the tray, returned it to the tray line, and began loading trays without performing hand hygiene. Observation on 06/17/2026 at 12:21 PM showed the facility walk-in freezer showed 10 F on the internal thermometer. Observation showed some items continued to be soft to the touch and not frozen. Observation on 06/17/2026 at 12:36 PM showed the facility's walk-in freezer continued to show 10 F on the internal thermometer. Observation on 06/17/2026 at 12:40 PM showed the trash can near the tray line had started overflowing and used paper towels had fallen out onto the tray line. Observation and interview on 06/17/2026 at 12:44 PM showed the facility's walk-in freezer contained large ice cream buckets which showed signs of being melted and then refrozen. Observation showed a large brown paper bag with popsicles which were sticky to the (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	touch. Staff P, Director of Operations, stated the single served ice creams were soft to the touch and should not have been. Staff P stated the large buckets of ice cream and paper bag of popsicles belonged to the activity department. During a joint interview on 06/17/2026 at 1:07 PM, Staff P, Director of Operations, stated facility dishwashers should remove gloves, perform hand hygiene, and don new gloves when moving between working with dirty and clean dishes. Staff P stated the observations of staff not changing gloves or performing hand hygiene when moving between dirty and clean dish sides did not meet expectations. Staff A, Administrator, stated the facility needed to re-wash all kitchen items to ensure they were not contaminated. Observation on 06/17/2026 at 2:46 PM showed the dry storage can rack contained two dented cans of mandarin oranges. During an interview on 06/22/2026 at 12:46 PM, Staff M, Dietary Manager, stated the facility put dented cans of food product in a separate area to be thrown away. Staff M stated dented cans would be used if they were not too damaged, which was when a can was dented in too far compared to a minor dent. Staff M stated the trash can at the handwashing sink could be used to dispose of used paper towels if the lid to the can was slid over a little bit, and, if it was not, staff could use a paper towel to slide it open. Staff M stated the facility's freezer had not been cooling correctly on 06/17/2026. During an interview on 06/22/2026 at 1:57 PM, Staff A, Administrator, stated the observation of stored and used dented cans did not meet expectations. Staff A stated the kitchen's handwashing sink should have a foot operated trashcan to avoid cross contamination when throwing away paper towels. Reference WAC 388-97-1100(3), -2980

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, the facility failed to ensure all planned and provided services were included in residents plans of care for 2 of 19 sampled residents (Residents 34 and 9) reviewed for comprehensive care plans. Failure to include Resident 34's denture use and Residents 34 and 9's oxygen use placed residents at risk of unprovided care, decline in clinical condition, and diminished quality of life. Findings included .Resident 34 Review of the electronic health record (EHR) showed Resident 34 readmitted to the facility on [DATE] with diagnoses to include chronic obstructive pulmonary disease (COPD, lung disease that causes restricted airflow and breathing problems), diabetes (high blood sugar), and anxiety disorder. Resident 34 was able to make needs known. Review of the quarterly minimum data set assessment (MDS) dated [DATE] showed Resident 34 received oxygen (O2) therapy and had broken or loosely fitting full or partial dentures. <Dentures> During an interview on 06/16/2026 at 12:40 PM, Resident 34 stated they had dentures; however, the bottom dentures did not fit right. Resident 34 stated the dentures were taken a few weeks ago to get fixed and had not got them back. Review of Resident 34's progress note dated 04/07/2026 showed, Resident received new dentures 4/6/2026. Review of the focused care plan for activities of daily living (ADL) self-care performance deficit, initiated on 01/30/2026, showed Resident 34 was independent with oral care; however, it did not show dentures. Review of the focused care plan for oral/dental health problems, initiated on 04/06/2026 showed Resident 34 had no teeth; however, it did not show dentures. During an interview on 06/18/2026 at 11:37 AM, Staff G, Resident Care Manager/Licensed Practical Nurse (RCM/LPN), stated Resident 34's dentures should have been care planned when they were received. During an interview on 06/18/2026 at 12:21 PM, Staff B, Director of Nursing Services (DNS), stated Resident 34's care plan should have been revised when the resident received dentures and should reflect the resident's current oral/dental status. <Oxygen> Observations on 06/16/2026 at 9:37 AM and 12:56 PM, 06/17/2026 at 1:11 PM, and 06/18/2026 at 10:27 AM showed Resident 34 with O2 set to 2 liters (L, the flow of O2 being delivered per minute) via nasal canula (NC, devise to deliver O2 through a tube into the nose) connected to an O2 concentrator (medical device that provides supplemental O2). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the June 2026 MAR showed Resident 34 had an order with a start date of 05/27/2026 for continuous O2 at 2L/minute via NC to keep oxygen saturation greater than 90% and to monitor saturation every shift for COPD. Review of the focused care plan for COPD showed Resident 34 was on O2 therapy; however, it was not initiated/created until 06/15/2026. During an interview on 06/18/2026 at 10:33 AM, Staff G, RCM/LPN, stated Resident 34 was on O2 therapy; however, the care plan was not initiated until 06/15/2026 and this did not meet their expectations. Staff G stated O2 therapy care plan should have been initiated when Resident 34 was readmitted from the hospital on [DATE]. During an interview on 06/18/2026 at 10:59 AM, Staff B, DNS, stated Resident 34's care plan for O2 therapy did not meet their expectations. Resident 9 Review of the EHR showed Resident 9 admitted to the facility on [DATE] with diagnoses of pneumonia (a lung infection), diabetes, and congestive heart failure (CHF, when the heart can no longer pump enough blood). The resident was able to make needs known. Review of the EHR showed Resident 9 had a provider order for oxygen at two liters per minute with a start date of 11/19/2025. Review of the minimum data set assessment (MDS) showed Resident 9 was receiving oxygen during their stay. Review of the current plan of care on 06/17/2026 for Resident 9 showed oxygen was not included. During an interview on 06/18/2026 at 10:28 AM, Staff C, RCM/LPN, stated Resident 9 should have had a care plan in place for the use of oxygen. During an interview on 06/18/2026 at 10:35 AM, Staff B, DNS, stated it was their expectation that residents with CHF who received oxygen had it included in their comprehensive care plan and this did not happen for Resident 9 but should have. Reference WAC 388-97-1020(1)(2)(a)(b)

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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** Based on observation, interview, and record review, the facility failed to provide oxygen therapy and hearing support in accordance with professional standards for 2 of 19 sampled residents (Residents 47 and 5) reviewed for quality of care. These failed practices placed the residents at risk for unmet needs and an inaccurate medical record. Findings included . Resident 5 Review of the electronic health record (EHR) showed Resident 5 readmitted to the facility on [DATE] with diagnoses to include anxiety disorder, personal history of other diseases of the respiratory system, and anemia (lack of healthy red blood cells to carry adequate oxygen to the body). Resident 5 was able to make needs known. Observations on 06/16/2026 at 12:07 PM and 06/17/2026 at 12:53 PM showed Resident 5 had an oxygen concentrator (medical device that provides supplemental oxygen) hooked to a nasal canula (devise used to deliver oxygen through a tube into the nose) in their room not in use. During an interview on 06/16/2026 at 12:07 PM, Resident 5 stated they used oxygen at night when they slept or if they were to take a nap. Review of the minimum data set assessment (MDS) dated [DATE] showed Resident 5 received oxygen therapy. Review of Resident 5's smoking care plan with an intervention initiated on 03/07/2024 showed, Patient is not on oxygen while out of bed, and no other mention of oxygen use was found in the resident's care plan. Review of Resident 5's EHR on 06/17/2026 showed no active orders for oxygen therapy. Observation on 06/18/2026 at 8:43 AM showed Resident 5 was not in their room; however, next to the resident's bed was an oxygen concentrator turned on at 4 liters (the flow of oxygen being delivered per minute) hooked to a nasal canula on the floor in the room. The oxygen tubing was dated 06/15/2026 and the plastic bag hanging off the oxygen concentrator had Resident 5's name written on it. During an interview on 06/18/2026 at 8:48 AM, Staff L, Certified Nursing Assistant (CNA), stated Resident 5 had told them that they used oxygen at night; however, they had not seen the resident use it during the day. During an interview on 06/18/2026 at 9:03 AM, Staff G, Resident Care Manager/Licensed Practical Nurse (RCM/LPN), stated Resident 5 had an oxygen concentrator in their room. Staff G stated if Resident 5 stated they used oxygen at night, then they believed it was being used at night. Staff G stated Resident 5 should have had oxygen orders in place and care planned if they were receiving oxygen therapy; however, there were no orders and oxygen therapy/use had not been care planned. During an interview on 06/18/2026 at 9:17 AM, Staff B, Director of Nursing Services (DNS), stated if Resident 5 stated they used oxygen at night and the equipment was in their room then it was likely (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that the resident received oxygen at night. Staff B stated if Resident 5 required oxygen therapy there should have been an assessment, provider orders, implemented equipment, care planned, and oxygen saturation (SATs, measuring the percentage amount of oxygen in the blood) monitored. Staff B stated Resident 5's nightly oxygen usage did not meet their expectations. Resident 47 Review of the EHR showed Resident 47 admitted to the facility on [DATE] with diagnoses to include dementia (a group of symptoms affecting memory). The resident was able to make needs known. During an interview and observation on 06/16/2026 at 1:40 PM, Resident 47 stated I can't hear you and smiled. There was no hearing aids noted in the resident's ears. During an interview and observation on 06/17/2026 at 11:28 AM, Resident 47 sat in their room watching the television, and no hearing aids were observed in the resident's ears. Review of the current plan of care on 6/17/2026 showed interventions for staff to place hearing aids in the morning and remove them to be charged in the evening. Review of the provider orders showed licensed nurses were to apply the hearing aids in the morning and remove them to charge at night, with a start date of 03/13/2024. Observation on 06/18/2026 at 9:09 AM showed Resident 47 with no hearing aid in place. During an interview on 06/18/2026 at 9:09 AM, Resident 47's roommate (Resident 78) stated [Resident 47] does not wear the hearing aids. They do not help. I think their son took them home a while ago. Review of the EHR showed staff documented in the medication administration record (MAR) from 06/01/2026 through 06/18/2026 that Resident 47 had their hearing aids placed in the mornings and removed to charge in the evening. During an interview on 06/18/2026 at 9:31 AM, Staff D, LPN, stated Resident 47's hearing aids did not work and maybe their son took them. Staff D stated they use a whiteboard to communicate. During an interview on 06/18/2026 at 9:34 AM, Staff E, CNA, stated Resident 47 did not like wearing the hearing aids. During an interview on 06/18/2026 at 9:37 AM, Staff B, DNS, stated this did not meet their expectations for Resident 47. Staff B stated Resident 47 did not wear the hearing aids and their son took them home because they do not help. Reference WAC 388-97-1620(2)(b)(i)(ii)(6)(b)(i)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure prompt dental services were provided for 1 of 3 sampled residents (Resident 114) reviewed for dental services. This failure placed the resident at risk for continued dental problems and a diminished quality of life. Findings included.Review of the electronic health record (EHR) showed Resident 114 admitted to the facility on [DATE] with diagnoses to include heart failure, diabetes (the body's inability to regulate blood sugar), and dysphagia (difficulty swallowing). Resident 114 was able to make needs known. During an interview and observation on 06/16/2026 at 1:03 PM, Resident 114 stated they would like to have dentures because they had no teeth and staff were aware; however, they still had no dentures. Resident 114 had no upper or lower teeth and no visible dentures in their room. Review of the annual minimum data set assessment (MDS) dated [DATE] showed Resident 114 had no natural teeth or tooth fragments. Review of Resident 114's EHR showed a focused care plan for activities of daily living self-care performance deficit, initiated on 09/27/2023, with an intervention for Oral Care: The resident has missing teeth. Upper/lower dentures not with [Resident 114]. The resident requires oral inspection. Report changes to the nurse. Set up assist with oral cavity cares, initiated on 09/27/2023 and revised on 06/14/2024. It showed a focused care plan for potential oral/dental health problems related to edentulous [no natural teeth]. Resident is waiting for dentures initiated on 10/05/2023 and revised on 05/29/2026. Review of Resident 114's dental/dentures visit/exam form dated 05/22/2024 showed the provider recommended new upper and lower dentures. It showed handwritten on the form, Pt. [patient] said dentures lost a few weeks ago. Pt. would like new dentures. Review of Resident 114's dental/dentures visit/exam forms, dated 09/16/2024 and 01/23/2025, showed the provider recommended new upper and lower dentures. Review of Resident 114's Washington State Heath Care Authority Denture/Partial Appliance Request For Skilled Nursing Facility Client, form dated 01/29/2025 showed it was signed by the provider on 02/14/2025 and had handwritten on the form Emailed 2/17/25 @ 10:06 AM. Review of Resident 114's dental/dentures visit/exam forms dated 06/09/2025 and 03/16/2026 showed the provider recommended new upper and lower dentures. During an interview on 06/18/2026 at 12:40 PM, Staff G, Resident Care Manager/Licensed Practical Nurse (RCM/LPN), stated they were not sure if Resident 114's denture request had been denied or not. Staff G stated that Staff Q, Central Supply/Transportation, would work with the denturist and the authorization process. Staff G stated that they should have been notified if the request had been denied and they had not been informed. Staff G stated on 05/05/2026 there was another request for Resident 114's dentures completed and it was emailed on 05/06/2026; however, this issue should have been addressed a lot sooner and this did not meet expectations. During an interview on 06/18/2026 at 1:06 PM, Staff Q, Central Supply/Transportation, stated they were not aware of Resident 114's denture request had been denied but could find out. Staff Q then called and spoke to the dental operations manager. Staff Q stated the dental operations manager stated that Resident 114's January 2025 denture request was denied due to needing additional information. Staff Q stated that Resident 114's denture request should have been addressed sooner, and this did not meet expectations. During an interview on 06/18/2026 at 1:57 PM, Staff A, Administrator, stated Resident 114's request for dentures should have been addressed sooner and this did not meet their expectations. Reference WAC 388-97-1060(1)

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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)
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** Based on observation, interview, and record review, the facility failed to follow infection control practices related to enhanced barrier precautions (EBP, infection control measures used in nursing homes to prevent the spread of resistant organisms) and hand hygiene for 1 of 2 sampled residents (Resident 12) when reviewed for activities of daily living and catheter (thin flexible tube inserted into the body to withdraw urine). These failures placed the residents at risk of infection, preventable illness, and diminished quality of life. Findings included.Review of the electronic health record (EHR) showed Resident 12 was readmitted to the facility on [DATE] with diagnoses to include heart failure, end of life care (hospice), and compression fracture in the lumbar (low back) area. Resident 12 was able to communicate needs. <Enhanced Barrier Precautions> Review of the care plan, initiated on 01/19/2026, showed Resident 12 was to have EBP (staff to wear gown and gloves [PPE, personal protective equipment] when completing high contact care) related to the use of a catheter. Observation on 06/17/2026 at 01:26 PM showed Staff H, Certified Nursing Assistant (CNA), answered Resident 12's call light and provided incontinence care without wearing an isolation gown, only gloves. During the care, Staff H touched the bed linen, privacy curtain, and Resident 12's gown with their uniform. Resident 12 was laying on full size bed and Staff H was leaning on to the bed to reach Resident 12's body. <Hand Hygiene> Observation on 06/17/2026 at 1:28 PM showed Staff H, CNA, removed the front part of Resident 12's incontinent brief and wiped loose stools with wipes, then Staff H touched the privacy curtain, bed linens, and pillow that was on the chair next to bed with the soiled gloves. Staff H did not change gloves or perform hand hygiene after touching stools and wiping. A second unidentified CNA came into the room with gown and gloves and assisted Staff H with turning Resident 12 and continued with wiping loose stools from the back. The second CNA changed gloves and did not perform hand hygiene. Observation on 06/17/2026 at 1:40 PM showed Staff J, Registered Nurse (RN), entered Resident 12's room and applied ointment. Staff J stated Staff H should not have provided care without proper PPE and hand hygiene. During an interview on 06/22/2026 at 12:43 PM, Staff B, Director of Nursing Services, stated the staff were to perform hand hygiene before putting on gloves when changing gloves and after using gloves. Staff B stated staff not following EBP and lack of hand hygiene did not meet expectations. Reference WAC 388-97 -1320 (1)(c) (2)(a)