STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505181	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redmond Care and Rehabilitation Center	7900 Willows Road Northeast Redmond, WA 98052

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on interview and record review, the facility failed to ensure an advance directive (a written instruction, such as a living will or Durable Power of Attorney [DPOA] for health care [a document delegating to an agent the authority to make health care decisions in case the individual delegating the authority subsequently becomes incapable to do so]) was obtained for 1 of 3 residents (Resident 14), reviewed for advance directives. This failure placed the resident and/or their representative at risk for losing their right to have their preferences honored to receive or refuse/discontinue care according to their choice. Findings included . Review of the facility's policy titled, Advance Directives and Associated Documentation, revised in April 2025, showed that Prior to, upon, or immediately after admission, a facility staff member shall .inquire whether they [residents] have completed an Advance Directive and if they had they should Obtain [a] copy of the Advance Directive .documents and place in the resident health record. Review of the facility's document titled, Advance Directive Receipt, dated [signed by Resident 14] on 08/28/2024, showed that Resident 14 marked that they had an advance directive and would provide a copy. Review of Resident 14's electronic health record under the miscellaneous tab reviewed on 06/08/2025, showed documentation that Resident 14 had a financial DPOA on file and did not show that there was a copy of Resident 14's advance directive. In an interview on 06/10/2025 at 9:15 AM, Resident 14 stated that they had an advance directive and that they thought they had provided a copy to the facility. In an interview and joint record review on 06/10/2025 at 9:18 AM, Staff K, Social Services, stated that the facility would ask residents at admission if they had an advance directive and would request a copy of their paperwork. A joint record review of Resident 14's DPOA document showed that it was a financial DPOA. Staff K stated, there's no mention of medical; I think this is for her finances. (continued on next page)

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and joint record review on 06/10/2025 at 3:42 PM, Staff M, Patient Advocacy Resource, stated that Resident 14's DPOA paperwork on file was financial. A joint record review of Resident 14's progress notes from 08/24/2025 through 06/09/2025, showed no documentation that there was follow up to obtain Resident 14's DPOA for healthcare. Staff M stated there were no progress notes showing that this was followed up on. Staff M further stated that they spoke with Resident 14 today [06/10/2025] and confirmed that Resident 14 had a DPOA for healthcare and they would be reaching out to get a copy of the paperwork to have on file. In a follow-up interview on 06/13/2025 at 9:42 AM, Staff K stated, it should be documented better and it could be documented in a progress note, when they followed up with a resident and/or their representative to get a copy of their advance directive. Staff K further stated that it was unclear based on the provided documentation that there was any follow-up to obtain Resident 14's advance directive paperwork before 06/10/2025. In an interview on 06/13/2025 at 11:39 AM, Staff A, Administrator, stated that a financial DPOA was not an advance directive. Staff A stated that if a resident said they had an advance directive, then we would need to get a copy and that it should be in the resident's medical record. Staff A further stated that they expected follow-up to be done as often, until it is received and that there should be documentation of the follow-up in a progress note. Reference: (WAC) 388-97-0280 (3)(a)(d) .

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** DISCHARGE STATUS RESIDENT 76 Review of the nursing progress notes printed on 06/09/2025 showed Resident 76 discharged home on [DATE]. Review of the discharge MDS dated [DATE] showed Resident 76 was admitted to the facility on [DATE] and was discharged on 03/15/2025. Further review of the MDS showed Resident 76 was marked they were discharged to the hospital in Section A2105 (Discharge Status). Section A2105 should have been marked discharge to Home/Community. In an interview and joint record review on 06/11/2025 at 11:09 AM, Staff D stated that they follow the RAI manual for completion of MDS assessments. A joint record review showed Resident 76's MDS dated [DATE] was marked discharged to the hospital. Staff D stated the MDS was marked discharged to the hospital and [Resident 76] did not go there. A joint record review of the progress notes dated 03/15/2025 showed Resident 76 discharged home. Staff D stated that Resident 76's discharge MDS was not accurate and that it should have been marked discharged to home/community. In an interview on 06/11/2025 at 11:15 AM, Staff B stated they expected MDS assessments to be completed accurately according to the RAI MDS Manual. Staff B further stated that Resident 76's MDS should have been marked to have discharged home and that their MDS was inaccurate. Reference: (WAC) 388-97-1000 (1)(b) Based on interview and record review, the facility failed to ensure resident assessments were completed accurately for 3 of 21 residents (Residents 19, 12, & 76), reviewed for Minimum Data Set (MDS-an assessment tool). The failure to ensure accurate assessments were coded on the MDS regarding diagnosis, medication use, and discharge status placed the residents at risk for unidentified and/or unmet care needs, and a diminished quality of life. Findings included . According to the Long-Term Care Resident Assessment Instrument (RAI) 3.0 User's Manual, (a guide directing staff on how to accurately assess the status of residents) Version 1.19.1, dated October 2024, showed, .an accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and should also include the resident's medical record, physician, and family, guardian and/or other legally authorized representative, or significant other as appropriate or acceptable. It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT [Interdisciplinary Team] completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Observation Period (also known as the Look-back period) is the time-period over which the resident's condition or status is captured by the MDS and ends at 11:59 PM on the day of the Assessment Reference Date (ARD or assessment period). DIAGNOSIS RESIDENT 19 Review of admission MDS dated [DATE], showed Resident 19 was not marked for dementia (a progressive condition that affects the brain) in Section I (Active Diagnosis - under I4800). Review of Resident 19's face sheet printed on 06/09/2025, showed Resident 19 had a diagnosis of dementia. Review of physician's progress notes dated 04/01/2025, showed Resident 19 had a diagnosis of dementia during the look-back-period (04/01/2025 to 04/07/2025). In an interview and joint record review on 06/12/2025 at 1:53 PM, Staff D, MDS Coordinator, stated they would follow the RAI Manual for MDS accuracy. A joint record review of Resident 19's physician progress notes dated 04/01/2025, showed Resident 19 had a diagnosis of dementia and was taking a medication for it. A joint record review of Resident 19's admission MDS dated [DATE], showed that dementia was not marked in Section I. Staff D stated Resident 19 should have been marked for dementia and that their MDS was not accurate. MEDICATION USE RESIDENT 12 Review of Resident 12's admission MDS dated [DATE], showed Resident 12 was not marked for antianxiety (medication for anxiety [having excessive/persistent worry and fear]) in Section N (Medications - under N0415B1 [taking, or receiving an antianxiety] and N0415B2 [indication noted-reason why the resident is taking it]) during the look-back period (05/21/2025 to 05/27/2025). Review of May 2025 Medication Administration Record (MAR) showed Resident 12 received an antianxiety medication on 05/22/2025, 05/23/2025, 05/25/2025, and 05/26/2025 during the look-back-period. A joint record review and interview on 06/12/2025 at 1:53 PM with Staff D, showed Resident 12 was not marked to have received an antianxiety medication during the look-back-period. A joint record review of Resident 12's May 2025 MAR showed they were administered an antianxiety during the look-back-period. Staff D stated that antianxiety should have been marked in Resident 12's assessment and that their MDS was not accurate. In an interview on 06/12/2025 at 3:00 PM, Staff B, Director of Nursing, stated that they expected the MDS to be completed accurately for Resident 19 and Resident 12.

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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. Based on observation, interview, and record review, the facility failed to implement a care plan for 1 of 5 residents (Resident 3), reviewed for comprehensive care plans. The failure to implement the care plan for communication placed the resident at risk for unmet care needs and a diminished quality of life. Findings included . Review of the facility's policy titled, Comprehensive Person-Centered Care Planning, revised in April 2025, showed that the facility will develop and implement a comprehensive person-centered .care plan for each resident that will include resident's needs, goals and desired outcomes. Review of a hearing clinic visit note dated 04/24/2024, showed that hearing instruments [hearing aids] were recommended for Resident 3. An additional visit note dated 05/24/2024, showed that Resident 3's representative reported that when the device is in her ear, she is able to hear him better. Review of the communication care plan printed on 06/08/2025, showed an intervention for left sided hearing [aid] kept in charger at bedside. Needs staff to place and remove. An observation on 06/08/2025 at 2:41 PM, showed Resident 3 with no hearing aids in their ears. Resident 3's representative stated that Resident 3 was hard of hearing, that they had hearing aids, and they aren't [are not] charged. Resident 3's representative further stated that the hearing aids had not been put in for a while. Additional observations on 06/09/2025 at 10:45 AM, on 06/10/2025 at 8:51 AM, at 11:48 AM, at 1:12 PM, on 06/11/2025 at 11:27 AM, and at 1:35 PM, showed Resident 3 had no hearing aids in their ears. In an interview and joint record review on 06/11/2025 at 1:38 PM, Staff I, Registered Nurse, stated that resident's care plans should be followed. A joint record review of Resident 3's communication care plan showed, left sided hearing [aid] kept in charger at bedside. Needs staff to place and remove. Staff I stated they were responsible for placing the hearing aid for Resident 3. Staff I stated, aides [CNA-Certified Nursing Assistant] can put them in and we [nurses] double check. A joint observation showed no hearing aids in Resident 3's ears. Staff I asked Staff L, CNA [who was also in the resident's room], where Resident 3's hearing aid was and Staff L stated, I don't [do not] know and she hasn't [has not] been using the hearing aid for a while. She doesn't [does not] like them. In an interview and joint record review on 06/12/2025 at 2:22 PM, Staff F, Resident Care Manager, stated that they expect staff to read it [care plans] and follow the care plan. Staff F stated that if the care plan said for staff to help place and remove hearing aids for a resident, then staff should follow the care plan. A joint record review of Resident 3's communication care plan showed that it had been updated on 06/12/2025 and now showed instructions that Resident 3's representative would be the one to charge the hearing aid. It further showed that Resident 3's representative or staff could place the hearing aid. Staff F stated, I [just] updated it [the care plan]. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/13/2025 at 11:16 AM, Staff B, Director of Nursing, stated that they expected staff to follow resident's care plans. Staff B further stated that they expected the licensed nurse to put on Resident 3's hearing aid if that was what the care plan showed. Reference: (WAC) 388-97-1020(2)(a) .

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on observation, interview, and record review, the facility failed to provide services to maintain hearing methods to carry out the Activities of Daily Living (ADL) for 1 of 1 resident (Resident 3), reviewed for communication. This failure placed the resident at risk of not being able to hear and/or communicate and a diminished quality of life. Findings included . Review of the facility's policy titled, Activities of Daily Living, revised on 04/03/2025, showed, A resident's abilities in ADL's do not diminish unless circumstances on the individual's clinical condition demonstrate that diminution [decline] was unavoidable. This includes the resident's ability to .use speech, language, or other functional communication systems. Review of Resident 3's quarterly Minimum Data Set (an assessment tool) showed that Resident 3 had minimal difficulty with hearing (difficulty in some environments, for example when a person speaks softly or the setting is noisy). Review of a hearing clinic visit note dated 04/24/2024, showed that hearing instruments [hearing aids] were recommended for Resident 3. An additional visit note dated 05/24/2024, showed that Resident 3's representative reported that when the device is in her ear, she is able to hear him better. Review of Resident 3's physician orders dated 05/17/2024, showed an order for, Left hearing aid on in the morning, off at night, or when uncomfortable every day and evening shift. It further showed instruction for the LN [Licensed Nurse to] put it ON [at] 0700 [7:00 AM] and take it OFF [at] 1800 [6:00 PM]. An observation on 06/08/2025 at 2:41 PM, showed Resident 3 with no hearing aids in their ears. Resident 3's representative stated that Resident 3 was hard of hearing, that they had hearing aids, and they aren't [are not] charged. Resident 3's representative further stated that the hearing aids had not been put in for a while. Additional observations on 06/09/2025 at 10:45 AM, on 06/10/2025 at 8:51 AM, at 11:48 AM, at 1:12 PM, on 06/11/2025 at 11:27 AM, and at 1:35 PM, showed Resident 3 had no hearing aids in their ears. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and joint record review on 06/11/2025 at 1:38 PM, Staff I, Registered Nurse, stated that nurses were responsible for placing hearing aids for residents that needed help with ADLs. Staff I stated that Certified Nursing Assistants (CNAs) could place them and that nurses would check to make sure they had been placed for the residents. Staff I stated that Resident 3 was hard of hearing and had one hearing aid. A joint record review of Resident 3's physician orders showed, Left hearing aid on in the morning, off at night, or when uncomfortable every day and evening shift. It further showed instruction for the LN [to] put it ON [at] 0700 and take it OFF [at] 1800, ordered on 05/17/2024. Staff I stated that the CNA had placed the hearing aid for Resident 3 today [06/11/2025]. When asked if they had confirmed hearing aid placement, Staff I stated, I thought so, I guess I didn't [did not]. A joint observation showed no hearing aids in Resident 3's ears. Staff I asked Staff L, CNA, where the hearing aid was and Staff L stated, I don't [do not] know and she hasn't [has not] been using the hearing aid for a while. She doesn't [does not] like them. Resident 3's representative stated that it had been a couple weeks since the hearing aid had been charged or placed for Resident 3. Staff I stated, I thought it was in. My mistake. In an interview on 06/12/2025 at 2:22 PM, Staff F, Resident Care Manager, stated that nurses were responsible for placing hearing aids for residents that needed help with ADLs. Staff F stated that CNAs could also help place resident's hearing aids and the nurses should be checking if it's [it is] in place. In an interview and joint record review on 06/13/2025 at 11:01 AM, Staff B, Director of Nursing, stated that if residents needed help with ADLs, including help placing hearing aids, staff should help them. Staff B stated that nurses were responsible for placing hearing aids for residents that needed help with ADLs. A joint record review of Resident 3's physician orders, showed an order for, Left hearing aid on in the morning, off at night, or when uncomfortable every day and evening shift. It further showed instruction for the LN put it ON [at] 0700 and take it OFF [at] 1800. Staff B stated that they expected the licensed nurse to put [it] on [hearing aid] at seven AM for Resident 3. Reference: (WAC) 388-97-1060(2)(b) .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** RESIDENT 14 An observation on [DATE] at 11:27 AM showed an opened bottle of biotin (a vitamin supplement) on Resident 14's nightstand. Resident 14 stated I try to take it [biotin] every day. Additional observations on [DATE] at 9:28 AM, on [DATE] at 9:17 AM, and at 1:12 PM, showed an opened bottle of biotin on Resident 14's nightstand. An interview and joint observation on [DATE] at 12:12 PM, Staff I, RN, stated that supplements were considered medications and that medications should be stored in a locked medication room or medication cart. When asked if medications could be stored at a resident's bedside, Staff I stated, No, [it] has to be in the cart. A joint observation showed an opened bottle of biotin on Resident 14's nightstand. Staff I stated that they were unsure if the opened bottle of biotin should be there. In an interview on [DATE] at 12:17 PM, Staff F, stated that medications should be stored in locked medication carts. Staff F further stated that if a resident was able to self-administer medications they could be kept at bedside and it's [it is] supposed to be in a locked drawer. In an interview on [DATE] at 12:50 PM, Staff B stated that medications should be stored in a locked medication room or medication cart. Staff B further stated that if a resident was able to self-administer medications then they should be stored in the drawer [in the resident's room] and should be locked. Reference: (WAC) 388-97-1300(2) Based on observation, interview, and record review, the facility failed to ensure drugs were properly labeled, and/or expired supplies were removed/discarded in accordance with current accepted professional standards for 2 of 5 treatment cart and/or medication cart (C Wing Treatment Cart and B Wing Medication Cart), and failed to properly store a supplement for 1 of 1 resident (Resident 14), reviewed for medication storage and labeling. These failures placed the residents at risk for receiving compromised or ineffective medications, unsafe medication administration, and potential adverse side effects. Findings included . Review of the facility's policy titled, Storage of Medications, revised in [DATE], showed, The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. The policy further showed, Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others. C WING TREATMENT CART (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A joint observation and interview on [DATE] at 10:04 AM, with Staff F, Resident Care Manager (RCM), showed an opened urea (moisturizes and softens rough and callused skin areas) care treatment cream that did not have an open date. Further joint observation of the urea cream showed a period after opening symbol (a graphic symbol on cosmetic and toiletry product packaging that indicates how long the product remains safe and effective after it has been opened) of 24 M (months), and it had no expiration date. Staff F stated that the urea cream was good for two years once it had been opened. Staff F further stated that they would expect there to be an open date once the medication had been opened. B WING MEDICATION CART A joint observation and interview on [DATE] at 10:20 AM with Staff I, Registered Nurse (RN), showed medication for Resident 2 labeled Gabapentin (used for facial pain) 100 mg (milligrams-a unit of measurement) capsules with an expiration date of [DATE]. Staff I stated that expired medication should not be in the medication cart and that it should have been wasted or discarded. On [DATE] at 12:50 PM, Staff B, Director of Nursing stated expired medication should not be stored in the medication cart. Staff B further stated when a treatment cream was opened, they expected staff to label it with an open date.

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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. Based on observation, interview, and record review, the facility failed to ensure food items were handled appropriately in accordance with professional standards of food safety for 32 of 75 residents (Residents 11, 3, 34, 128, 4, 178, 66, 28, 30, 33, 55, 182, 17, 51, 59, 36, 63, 74, 230, 183, 231, 44, 49, 7, 72, 52, 1, 13, 26, 53, 68 & 61), reviewed for food services. This failure placed the residents at risk of food-borne illness (caused by the ingestion of contaminated food or beverages) and a diminished quality of life. Findings included . Review of the facility's policy titled, Food Procurement, Storage, and Distribution, revised on 07/08/2022, showed that the facility would store, prepare, distribute, and serve food in accordance with professional standards for food safety. The policy further showed that the facility would follow proper sanitation or food handling practices to prevent the outbreak of foodborne illness. Observation on 06/11/2025 from 11:32 AM to 12:34 PM, showed Staff G, Cook, with gloves on touched the meal cart, meal tickets, and the preparation table area. Using the same gloves, Staff G, started to place fresh parsley on the residents' plates for Resident 11, Resident 3, Resident 34, Resident 128, Resident 4, Resident 178, Resident 66, Resident 28, Resident 30, Resident 33, Resident 55, Resident 182, Resident 17, Resident 51, Resident 59, Resident 36, Resident 63, Resident 74, Resident 230, Resident 183, Resident 231, Resident 44, Resident 49, Resident 7, Resident 72, Resident 52, Resident 1, and Resident 13. At 12:30 PM, Staff G washed their hands and put on new gloves, touched the meal cart, meal tickets, preparation table area, and a bag of bread. While wearing the same gloves, Staff G continued to place fresh parsley on the residents' plates for Resident 26, Resident 53, Resident 68 and Resident 61. In an interview on 06/11/2025 at 12:36 PM, Staff G stated that their process for serving food items was to use serving utensils to place food items on residents' plates. Staff G stated that they did not use a serving utensil and/or a serving tong to place fresh parsley on the residents' plates and that they should have. In an interview on 06/11/2025 at 12:37 PM, Staff H, Dietary Supervisor, stated they expected food items to be served using serving utensils. Staff H stated that Staff G should not have touched fresh parsley with gloved hands to place them on residents' plates after touching the meal carts, meal tickets, meal trays, serving/preparation table, and the bag of bread. Staff H further stated that Staff G should have used a serving utensil to place the fresh parsley on the residents' plates. Reference: (WAC) 388-97-1100 (3) .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505181	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redmond Care and Rehabilitation Center	7900 Willows Road Northeast Redmond, WA 98052

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 ensure hand hygiene/glove use practices were followed for 1 of 4 staff (Staff J), reviewed for infection control. This failure placed the residents, visitors, and staff at an increased risk for infection and related complications. Findings included . Review of the facility's policy titled, Infection Prevention and Control Program, revised in April 2025, showed that facility personnel will handle, store, process, and transport linens so as to prevent the spread of infection and the facility will use effective methods for the safe storage, transport and disposal of garbage, refuse and infectious waste. An observation on 06/08/2025 at 9:20 AM, showed Staff J, Certified Nursing Assistant, took soiled material in a plastic bag from room [ROOM NUMBER] to the soiled utility room. It further showed Staff J wearing gloves on both hands while they carried the plastic bag in the hallway and touched the soiled utility room door handle with their soiled gloved hand. Additional observations on 06/08/2025 at 9:50 AM and 11:58 AM showed Staff J carried soiled material in a plastic bag through the hallway to the soiled utility room while wearing gloves on both hands. It further showed Staff J used their soiled gloved hand to touch the soiled utility room door handle, put the soiled material in the soiled utility room, removed the soiled gloves in the hallway and put in the garbage container in the hallway, and then performed hand hygiene. In an interview on 06/08/2025 at 12:21 PM, Staff J stated that their process for carrying soiled linens or soiled material was to put on gloves, put [soiled material] in a plastic bag, tie it up, put in [the] soiled utility room, take off [their] gloves and do hand hygiene. Staff J stated that they wore gloves while carrying the soiled material in the hallway, because [they were] holding something contaminated. Staff J further stated that they touched the soiled utility room door handle with their soiled gloves. In an interview on 06/13/2025 at 9:40 AM, Staff C, Infection Preventionist, stated that they expected staff to transfer soiled items to the soiled utility room by putting [soiled items] in a bag, take off [their soiled] gloves, perform hand hygiene, pick back up [the soiled items] and take to the soiled utility room. Staff C stated that staff should not wear gloves in the hallway unless they were cleaning equipment. Staff C further stated that staff should not touch door handles while wearing [soiled] gloves. In an interview on 06/13/2025 at 11:01 AM, Staff B, Director of Nursing, stated that staff should not wear gloves in the hallway while carrying soiled items to the soiled utility room and they should not touch the soiled utility room door handle with their gloves. Staff B further stated that these practices were a risk for spreading infection. Reference: (WAC) 388-97-1320(1)(a) .