STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505265	A. Building B. Wing	03/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerald Care	209 North Ahtanum Avenue Wapato, WA 98951

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117 Based on observation, interview, and record review, the facility failed to ensure resident care plans were reviewed and revised to accurately reflect care needs for 1 of 3 residents (Resident 40) reviewed for dental services and choices, and 1 of 1 resident (Resident 66) reviewed for transfers and meal assistance. The failure to revise care plans to reflect current care needs placed the residents at risk for inadequate or unsafe care. Findings included . Review of the facility policy titled, Plan of Care, dated 09/18/2019, showed each resident would have a plan of care that described the services provided to the residents to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being as well as any other services that would be otherwise be required are not provided due to the resident's exercise of rights including to refuse treatments. Further review showed changes were made to the plan of care anytime the resident's condition or need warranted it (including temporary issues). <Dental> <Resident 40> Review of the medical record showed Resident 40 was admitted to the facility on [DATE] with diagnoses including heart failure and end stage renal disease [permanent kidney failure that requires dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly]). The 12/31/2023 comprehensive assessment showed the resident was independent with activities of daily living (ADLs), required set up assistance of one staff member for meals, and partial/moderate assistance of one staff member for showering. The assessment also showed the resident had an intact cognition. Record review of Resident 40's care plan dated 01/19/2024, showed a focus area for oral/dental health problems related to missing and carious (decayed) teeth, has few remaining natural teeth. Additional review of the care plan showed ORAL CARE: I have my own teeth. I am missing several teeth . Review of Resident 40's physician's progress note, dated 10/06/2023, showed the resident had all of their teeth removed on 10/06/2023. A second physician progress note on 11/06/2023 showed Resident 40 had impressions taken for their dentures. They received a full set of dentures on 02/05/2024. (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/27/2024 at 12:33 PM, Resident 40 stated they had all of their teeth removed a few months ago. They stated they normally wore their dentures but ran out of denture adhesive and was waiting for it to come in the mail. During an interview on 03/04/2024 at 12:47 PM, Staff D, Restorative Director, stated they were responsible for updating the care plan for oral cares. Staff D stated Resident 40 received their new dentures the first week of February 2024 and they had not had time to update Resident 40's care plan. <Informed Choice/Refusal of Treatment> Record review of Resident 40's physician orders showed a physician order dated 01/02/2024 for a renal (referring to the kidney) diet (a diet aimed at keeping levels of fluids, electrolytes, and minerals balanced in the body in individuals who were on dialysis), regular texture foods, thin liquids, and a 1000 cubic centimeter (cc - a unit of volume of liquids) daily fluid restriction. Review of Resident 40's medical record showed a Resident Informed Choice/Refusal of Treatment form, signed, and dated by the resident on 04/25/2022, indicating a refusal to follow the physician ordered 1000 cc fluid restriction. Further review of the medical record showed Resident 40 signed a second Resident Informed Choice/Refusal of Treatment form on 01/02/2024, indicating a refusal of ground meats recommendation for meals while waiting for their dentures. The form showed the resident wanted regular texture meats/foods. Review of Resident 40's care plan, dated 01/19/2024, showed a focus area for nutritional problems with interventions including a total fluid goal of less than 1000 cc daily and a regular texture diet. There were no interventions or care plan revisions that showed the resident had refused their initial ground meat diet texture and fluid recommendations, despite the signed Resident Informed Choice/Refusal of Treatment forms. During an interview on 03/04/2024 at 11:29 AM, Staff F, Registered Nurse/Resident Care Manager (RN/RCM) stated the Resident Informed Consents/Refusal of Treatment forms should have been identified on Resident 40's care plan. <Transfers> <Resident 66> Review of the medical record showed Resident 66 was admitted to the facility on [DATE] with diagnoses including epilepsy (a brain disorder that causes recurring, unprovoked seizures that may include abnormal behaviors and loss of consciousness) and a stroke with left sided hemiplegia (a severe or complete loss of strength or paralysis on one side of the body) and hemiparesis (a mild or partial weakness or loss of strength on one side of the body). The 12/11/2023 comprehensive assessment showed the resident required partial/moderate assistance of one staff member for sit-to-stand and toileting transfers, and set-up/clean up assistance for eating. The assessment also showed the resident had a moderately impaired cognition. Record review of Resident 66's care plan, dated 09/04/2023, showed the resident required one person stand by assistance for transfers with gait belt, have it on for precautions .do not use my underarms to help with transfer . (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 02/29/2024 at 8:11 AM, showed Resident 66 sitting in their wheelchair in their room, waiting for staff to bring them a cup of coffee. Resident 66 attempted to self-transfer to their bed as Staff S, Beautician, arrived with their coffee. Staff S put Resident 66's call light on for assistance. Staff L, Nursing Assistant, Staff M, NA, and Staff N, NA, entered the room to assist the Resident. Staff L and Staff M placed a gait belt around Resident 66's waist. Staff L and Staff M stood on each side of the resident's wheelchair and, each placing their arm under the residents' arms, transferred the resident to their bed. There was an under pad on Resident 66's bed that became wrinkled when the resident laid on the bed. Staff L and Staff M, using the same underarm technique, transferred the resident back to their wheelchair. Staff N smoothed out the bedding and under pad, and Staff L and Staff M transferred Resident 66 back into bed, using the same underarm technique. During an interview on 03/04/2024 at 8:01 AM, Staff O, NA/Rehab, stated Resident 66 transferred with extensive assistance of one staff member, but had some changes recently and would have to check the resident's care plan. During an interview on 03/04/2024 at 8:06 AM, Staff P, NA, stated they transferred Resident 66 with two people, and they used the underarm lift to transfer them. During an interview on 03/04/2024 at 8:14 AM, Staff L stated they used two people and a gait belt to transfer Resident 66. Staff L stated it was very hard to get the resident up and they used an underarm lift to transfer them. During an interview on 03/04/2024 at 12:47 PM, Staff D, Restorative Director, stated Resident 66 transferred with stand by assistance of one staff member. Staff D stated they were not aware that staff were transferring Resident 66 with two staff members. During an interview on 03/24/2024 at 11:29 AM, Staff F stated Resident 66 required assistance of two staff members for transfers, and staff should not be using the underarm lift technique with the resident. Staff F stated Resident 66's care plan was not correct and that it needed to be updated. <Meal Assistance> Record review of Resident 66's care plan, dated 09/04/2023, showed the resident required one to one assistance from staff for eating in their room for continued cueing or needed to eat in the dining room at a supervised table. An observation on 02/28/2024 at 8:32 AM, showed Resident 66 lying in their bed in a semi-reclined position independently eating their breakfast. There were no staff members in the resident's room. During an observation on 02/29/2024 at 12:25 PM, Resident 66 was in their bed, in a semi-reclined position, visiting with their family and eating their lunch without staff assistance. During an interview on 02/29/2024 at 10:57 AM, Staff Q, Licensed Practical Nurse (LPN), stated Resident 66 was able to feed themselves and did not require staff assistance. During a concurrent interview on 03/04/2024 at 12:47 PM, Staff D stated Resident 66 ate independently. Staff O stated that the resident was supervised in the dining room at the rehab table, but they did not need the supervision. Staff D stated Resident 66's care plan needed to be updated. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/04/2024 at 11:53 AM, Staff B, Director of Nursing Services, stated the process was the licensed nurses were to update resident care plans with any change in the resident that may arise. Staff B stated the care plans needed to be updated. During an interview on 03/04/2024 at 2:17 PM, Staff A, Administrator, stated the care plans needed to be tightened up (clearer, stronger, or more definite). Reference: WAC 388-97-1020(1)(2)(a)(4)(b)(5)(b)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117 Based on observation, interview, and record review, the facility failed to ensure residents received ongoing communication and collaboration with the dialysis (a process to remove waste products and excess fluid from the blood when the kidneys stop working properly) center for 3 of 3 residents (Resident 40, 44, and 38) reviewed for dialysis services. The failure to communicate and collaborate with the dialysis center as required, placed the residents at risk for unnoticed significant changes in their health status, delay in care, and death. Findings included . Review of the facility policy titled, Hemodialysis (a process of filtering the blood of a person whose kidneys were not working properly), dated 03/2023, showed the facility would ensure ongoing communication and collaboration with the dialysis facility regarding dialysis care and services. Additionally, the licensed nurse would communicate to the dialysis center via telephone or written form, such as a dialysis communication form, that included the following: Medication administration (initiated, held, or discontinued) by the facility or dialysis center; Physician/treatment orders, laboratory values, and vital signs (measurements that reflect essential body functions including heart rate, breathing rate, temperature, and blood pressure); Advance directives (a legal document that describes treatment preferences in end-of-life situations) and code status (instruction regarding personal preferences if a person suffers a heart attack); Nutritional/fluid management including weights, compliance with food/fluid restrictions, and monitoring intake and output measurements as ordered; Dialysis treatment provided and the residents response to treatment, including decline in functional status, and falls; Dialysis adverse reactions, complications, and/or recommendations for follow up observation and monitoring, and/or concerns related to the vascular access site (a joining of an artery and a vein in the arm to connect a dialysis machine to the bloodstream); Changes and/or declines in condition unrelated to dialysis; The occurrence or risk for falls related to transportation to/from the dialysis center. Review of the facility contract titled Nursing Home Dialysis Transfer Agreement, dated 04/14/2021, showed the dialysis center would provide the facility information on the aspects of the management of a designated resident's care related to dialysis services. The contract showed the facility would ensure appropriate medical, social, administrative, and other information accompany all designated residents at the time of transfer to the dialysis center, including: The residents name, address, date of birth, and social security number; (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Contact information for the residents next of kin; Third party payor information; Appropriate medical records, including a history of illness, including laboratory and x-ray findings; Treatment presently provided to the resident, including medications and any change in the resident's condition, change of medication, diet and/or fluid intake; Any advance directive executed by the resident; Any other information that would facilitate coordination of care. <Resident 40> Review of the medical record showed Resident 40 was admitted to the facility 09/11/2021 with diagnoses including diabetes (a condition in which the body has trouble controlling blood sugar and using it for energy) and end stage renal disease (a medical condition where the kidneys stop functioning on a permanent basis, leading to the need for long term dialysis). The 12/31/2023 comprehensive assessment showed the resident was independent with activities of daily living (ADLs) and received hemodialysis. The assessment also showed the resident was cognitively intact. Review of the medical record showed Resident 40 received dialysis treatments every Tuesday, Thursday, and Saturday at an outside dialysis treatment center. Review of Resident 40's medication administration record (MAR) dated December 2023, showed the resident had 13 dialysis sessions. The January 2024 MAR showed Resident 40 had 13 dialysis sessions, and the February 2024 MAR showed the resident had 13 dialysis sessions. Review of Resident 40's medical record from 12/01/2023, through 03/01/2024, showed the dialysis center provided communication to the facility for three sessions; 12/04/2023, 12/12/2023, and 02/16/2024. There was no additional documentation of communication with the dialysis center in the record. Review of Resident 40's nursing progress notes showed on 01/23/2024 at 5:45 AM, the resident refused to go to the dialysis center. A call was placed to the dialysis center to inform them of the cancelled session. A second call was placed later that day at 9:41 AM to reschedule the appointment. There was no other documentation from 12/01/2023, through 03/01/2024, that showed any communication with the dialysis center. <Resident 44> Review of the medical record showed Resident 44 was admitted to the facility on [DATE] with diagnoses including end stage renal disease, dependence on dialysis, and fluid overload (a condition of too much fluid volume in the body). The 12/14/2023 comprehensive assessment showed the resident was independent with ADLs and required hemodialysis. The assessment also showed the resident had an intact cognition. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record showed the resident had dialysis sessions scheduled for every Tuesday, Thursday, and Saturday at an outside dialysis treatment center. Review of Resident 44's MAR's dated December 2023, January 2024, and February 2024 showed the resident had 13 dialysis sessions each month. Review of Resident 44's medical record from 12/01/2023, through 03/01/2024, showed communication received from the dialysis center dated 01/30/2024. There were no other documents from the dialysis center during that time. Review of a nursing progress note late entry dated 03/04/2024, showed on 02/28/2024, Resident 44 had returned from the dialysis center and had blood saturated dressings at the vascular access site. There was no documentation that the dialysis center had been notified of the adverse reaction. Additional review of nursing progress notes from 12/01/2023 through 03/01/2024 showed one progress note, dated 12/02/2023 at 2:31 PM, a telephone call to the dialysis center to reschedule an appointment. There were no other documented communications with the dialysis center. <Resident 38> Review of the medical record showed Resident 38 was admitted to the facility on [DATE] with diagnoses including end stage renal disease and dependence on dialysis. The 02/13/2024 comprehensive assessment showed Resident 38 was independent with ADLs and required hemodialysis. The assessment also showed the resident was cognitively intact. Review of the medical record showed the resident had dialysis sessions scheduled every Tuesday, Thursday, and Saturday at an outside dialysis treatment center. Review of Resident 38's MAR's dated December 2023, January 2024 and February 2024 showed the resident had 13 dialysis sessions each month . Review of Resident 38's medical record from 12/01/2023 through 03/01/2024 showed communication was received from the dialysis center on 12/01/2023, 12/06/2023, 12/12/2023, 01/08/2024, and 01/30/2024. There was no additional documentation of communication from the dialysis center. Review of nursing progress notes dated 12/01/2023 through 03/01/2024, showed a progress note dated 12/22/2023 at 3:17 PM, showed a call from the facility to the dialysis center to reschedule an appointment for Resident 38. Further review of nursing progress notes showed on 01/11/2024 at 10:15 AM, a telephone call was received from the dialysis center with a physician order change for Resident 38. There was no other documentation of communication with the dialysis center. During an interview on 02/29/2024 at 10:56 AM, Staff Q, Licensed Practical Nurse, stated the facility did not send any paperwork or communication with the residents when they went to their dialysis sessions. They stated they did not receive any communication back from the dialysis center when the resident returned from their session. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/29/2024 at 11:01 AM, Staff F, Registered Nurse/Resident Care Manager (RN/RCM), stated the dialysis center would send a fax with updates as needed. They stated if they had questions or concerns, they would call the dialysis center. Staff F stated there was no system for communication, they would just call the dialysis center if they had a concern. Staff F stated they did not send any form of communication with the resident when they went to their dialysis session. During an interview on 03/01/2024 at 11:02 AM, Staff G, RN/RCM, stated the dialysis center would usually send over a fax sheet with information the same day or the day after the resident had a dialysis session, but lately we have not gotten them. Staff G stated they were unsure why they were not getting the faxes. Staff G stated they did not send any communication regarding the resident's current condition to the dialysis center. During an interview on 03/01/2024 at 12:00 PM, Staff B, Director of Nursing Services (DNS), stated the dialysis center would occasionally send over a change in condition or information from the dialysis session. They stated there needed to be a better system in place to follow the resident to and from the dialysis center. During an interview on 03/01/2024 at 12:36 PM, Staff R, Administrator in Training, stated the facility used to have books for tracking dialysis sessions but were unsure why they no longer had them. They stated they used to call for faxes after resident dialysis sessions, but no longer did that. Staff R stated they did not have a system in place for transfer of resident information with the dialysis centers. During a follow up interview on 03/04/2024 at 11:53 AM, Staff B stated phone calls were not a good system for communication. Staff B stated they were not aware that there was not a system for communication in place. During an interview on 03/24/2024 at 2:17 PM, Staff A, Administrator, stated they were not aware that the dialysis program was not functioning as it should. They stated they used to have communication with the dialysis centers, but that communication was not happening. Reference: WAC 388-97-1900(1)(6) (a-c)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45642 Based on observation, interview, and record review, the facility failed to ensure infection prevention and control practices were maintained for 2 of 2 residents (Resident 26, and 21) by staff not performing hand hygiene and glove changes between dirty and clean tasks (after touching the resident and/or the resident's environment during hydration pass, personal care, and wound care dressing change). These failures placed residents at an increased risk for exposure to cross contamination (harmful spread of infections) and the development of communicable diseases. Findings include . Review of a facility policy titled Hand Hygiene dated 01/28/2023 showed: The use of gloves does not eliminate the need for hand hygiene. Perform hand hygiene before placing gloves. Change gloves during resident care if moving from a contaminated body site to a clean body site. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before caring for another resident. During an observation of a hydration pass on 02/27/2024 between 2:19 PM and 3:00 PM, Staff E, Smoking Assistant, with their gloves on, went into room [ROOM NUMBER], brought out a contaminated resident cup from the first bedside table, filled the cup up with ice over the ice chest in the hallway and returned the resident cup to the first bedside table. Staff E was then observed in the same gloves to grab a contaminated resident cup from the second bedside table and brought it out into the hallway, filled the cup with ice over the ice chest and returned the contaminated cup to the second bedside table, removed gloves, and continued to the next room. During the same observation, Staff E put on their new gloves, entered room [ROOM NUMBER] and grabbed a resident contaminated cup from the first bedside table that contained water. Staff E then went into the hallway placed the contaminated cup over the ice chest, filled it with ice and the water splashed into the ice chest. Staff E then continued to room [ROOM NUMBER], with the same gloves on and grabbed the contaminated cup from the first bedside table, brought the cup to the ice chest and filled it up with ice over the ice chest and returned the cup to the first bedside table. Staff E with the same gloves then grabbed a contaminated cup from the second bedside table and repeated the same process. During an observation of a hydration pass on 02/28/2024 between 2:00 PM and 3:00 PM, Staff E, wearing their gloves, entered room [ROOM NUMBER] grabbed a contaminated cup from the first bedside table that contained water in it, brought it into the hallway, held the cup over the ice chest and then proceeded to fill the cup with the ice as water splashed back into the ice chest of ice. Staff E, with the same gloves, then grabbed the second cup from the room and proceeded to do the same thing with the second cup as the water splashed into the ice chest. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the same observation, between 2:00 PM and 3:00 PM, Staff E then went down the hall with the hydration cart, entered room [ROOM NUMBER], grabbed a contaminated cup from the first bedside table that was half filled with water, placed it over the ice chest, filled it with ice and shook the excess water off the cup into the ice chest. Staff E then went back into room [ROOM NUMBER] with the cup and with the same contaminated gloves, grabbed a contaminated cup from the second bedside table and repeated the same process. In a concurrent observation and interview on 02/29/2024 at 2:26 PM, Staff E put gloves on, entered room [ROOM NUMBER] and removed a dirty cup from the first bedside table, emptied the cup, placed the cup over the ice chest, filled it with ice and returned the dirty cup to the first beside table. Staff E then with the same gloves on grabbed a dirty cup from the second bedside table, emptied the water, placed the cup over the ice chest, filled it with ice and returned the dirty cup to the second bedside table. Staff E stated that the former employee (Smoking Assistant) had trained them on how to do the hydration pass. Additionally, Staff E stated the kitchen would set up the hydration cart. Staff E stated that they changed the resident cups at night or if the cup was visibly dirty. During an interview on 02/29/2024 at 2:42 PM, Staff I, Registered Dietician, stated the kitchen staff would set up the hydration cart with resident cups and an ice chest. The smoking assistant would then fill the ice chest with ice when they started their shift. Staff I further stated that the cups were to be changed out twice a day, once on night shift and once in the afternoon. The smoking assistant would then bring the cups back to the kitchen to be washed. <Resident 26> Review of the medical record showed Resident 26 had diagnoses to include dementia, weakness, and retention of urine. The comprehensive assessment, dated 12/29/2023, showed the resident had moderate cognitive impairment and required substantial/maximal assistance with personal and toileting hygiene. During an observation and concurrent interview on 02/29/2024 at 12:42 PM, Staff K, Nursing Assistant (NA), explained incontinent care to Resident 26. Staff K wiped down the front of Resident 26's groin, did not change their gloves after cleaning the groin and with their same contaminated gloves, grabbed the clean wipes to proceed with the resident's incontinent care. Staff K acknowledged that they should have changed their gloves when going from dirty to clean task of incontinent care. <Resident 21> Review of the medical record showed Resident 21 had diagnoses to include dementia, localized swelling to both lower legs, weakness, and cellulitis (bacterial skin infection) of the right lower leg. The comprehensive assessment dated [DATE] showed the resident had moderate cognitive impairment and required substantial/maximal assistance with lower body dressing and personal hygiene. (continued on next page)

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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 - Some	An observation on 03/01/2024 at 9:12 AM, showed Staff H, Registered Nurse (RN), during a wound care dressing change for Resident 21, had gloves on while removing the soiled dressing from the resident's right leg. After removing the dressing, Staff H did not change their gloves, did not clean the right leg with wound cleanser, and began applying Aquaphor (a moisturizing ointment) to the lower right leg. With the same contaminated gloves, Staff H then applied gauze around the lower right leg and secured the gauze with Coban (a self-adherent bandage). Staff H then removed their contaminated gloves and placed new gloves on without performing hand hygiene. Staff H began removing the contaminated dressing from the left lower leg, in the same gloves, did not cleanse the left lower leg, applied Aquaphor and a medicated ointment the left lower leg. Staff H then changed gloves and wrapped the left lower leg with gauze and Coban. Review of the medical record for Resident 21, showed a physician order dated 02/11/2023 was to cleanse both lower legs with wound cleanser, pat dry, apply Aquaphor ointment then wrap both legs with 2-layer wrap. An additional physician order dated 02/08/2024 was to apply Tacrolimus External Ointment (a medicated ointment) to the left lower leg once daily with leg wraps. During an interview on 03/01/2024 at 9:44 AM, Staff C, Infection Preventionist (IP), stated all staff received an online training and the smoking assistants received training from the former smoking assistant staff member on how to do the hydration pass. Staff C stated the smoking assistants have had hand hygiene training, also they attend all nursing assistant trainings. Additionally, Staff C acknowledged that the wound care for Resident 21 had been done incorrectly. Staff C stated the nurse should have followed the physician orders, that the wound should have been cleansed and gloves should have been changed during the wound care/dressing change. During an interview on 03/01/2024 at 10:32 AM, Staff B, Director of Nursing Services (DNS), stated the expectation was the nurses were to follow physician orders, the policies, and procedures for resident care and that all staff were to follow basic hand hygiene procedures when providing care to the residents. Reference: WAC 388-97-1320 (1)(a)(c)