STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505299	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Puget Sound Care	4001 Capitol Mall Dr Southwest Olympia, WA 98502

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure bowel interventions were initiated for 3 of 7 sampled residents (Resident 8, 4 & 25) reviewed for constipation, failed to follow physician's orders for insulin administration and dressing change for a peripherally inserted central catheter (PICC, a flexible tube inserted in the vein, and near the heart for long-term antibiotics administration) for 1 of 1 residents (Resident 25) and failed to obtain weekly weights for 1 of 5 residents (Resident 36) reviewed for quality of care. These failures placed residents at risk for discomfort, health complications and a diminished quality of life. Findings included . Constipation Record review of the facility policy, titled, Management of Constipation, updated, November 2023, documented: When a resident is identified with No/small Bowel Movement (BM) documented for 64 hrs [hours], the LN [Licensed Nurse] will assess the resident and determine if the bowel protocol will be initiated. -The Clinical Alert will be cleared using the progress note function to document findings and interventions. Standard bowel protocol to relieve constipation (in the absence of a bowel obstruction) with a provider order may include the following: Miralax [laxative] PO [by mouth] after eight shifts of no BM Compound Laxative, consisting of 17.2 mg [milligrams] of Senna [laxative] and of 10 mg [milligrams] Bisacodyl [laxative] Bisacodyl suppository rectally, if no result from the compound laxative Fleet Enema rectally, if no results from bisacodyl suppository. Resident 8 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set, (MDS), an assessment tool, dated 12/16/2025, documented Resident 8 was moderately cognitively impaired. Record review of Resident 8's Bowel and Bladder Elimination task sheet, dated January 2026, showed Resident 8 had a BM on 01/03/2026 at 9:04 PM, and did not show another BM until 01/09/2026 at 4:59 PM, over 139 hours (five days) since her previous documented BM.Record review of Resident 8's (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	January 2026 Medication Administration Record (MAR) showed the bowel protocol was not initiated between the dates of 01/03/2026 and 01/09/2026.In an interview on 01/23/2026 at 10:05 AM, Staff D, Unit Manager (UM)/Licensed Practical Nurse (LPN), said bowel protocol should be initiated and addressed on day two of no BM. Staff D was unable to produce documentation showing bowel protocol was started and documented for Resident 8. Staff D stated, There should be documentation follow up, but nothing is there. Staff D said he would expect for something to be given to Resident 8 around the 6th.In an interview on 01/23/2026 at 10:47 AM, Staff B, Director of Nursing Services/Registered Nurse (RN), said the bowel protocol should have been initiated and documented per facility policy. Staff B said Resident 8 has had consistent BMs and the time period in question was a matter of insufficient documentation. Resident 4 was admitted to the facility on [DATE]. The 5-Day MDS, dated [DATE], showed Resident 4 was alert and oriented. Review of Resident 4's BM task sheet, dated 12/24/2025 to 01/22/2026, documented Resident 4 had a BM on 12/28/2025 at 5:59 AM. Resident 24's next BM was on 01/01/2026 at 5:50 AM, over 95 hours since the last BM. Review of Resident 4's December 2025 and January 2026 Medication Administration Records did not show documentation Resident 4 received any bowel interventions between 12/28/2025 and 1/01/2026. Resident 25 was admitted to the facility on [DATE]. The quarterly MDS, dated [DATE], showed Resident 25 was alert and oriented. Review of Resident 25's BM task sheet, dated 12/25/2025 to 01/23/2026, documented Resident 25 had a BM on 01/09/2026 at 1:59 PM. Resident 25's next BM was on 01/15/2026 at 9:39 PM, over 151 hours since the last BM. Review of Resident 25's January 2026 MAR did not show documentation Resident 25 received any bowel interventions between 01/09/2026 and 01/15/2026. During an interview on 01/23/2026 at 10:55 AM, Staff B said she believed Resident 4 and Resident 25 were incontinent of bowel and that the missing documentation was a matter of the staff not documenting BMs. During an interview on 01/23/2026 at 1:41 PM, Staff B said she tried to find some documentation to show they were tracking Resident 4 and Resident 25 for norovirus. Staff B said there should have been some documentation of their BMs but she could not find any. PICC dressing change Record review of facility policy, titled, Infusion Therapy Policy & Procedure Manual, undated, documented, Measure external length of PICC .at insertion, with each dressing change and when clinically indicated if catheter dislodgment is suspected. Compare to measurement obtained at insertion. Resident 36 was admitted to the facility on [DATE] with multiple diagnoses to include Type 2 Diabetes (high blood sugar levels) and Congestive Heart Failure (hearts inability to effectively pump (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	blood). The admission MDS, dated [DATE], showed Resident 36 was moderately cognitively impaired. Record review of Resident 36's physician's order, dated 01/06/2026, documented, IV [intravenous, in the vein] Catheter [tube] - Location: LUE [left upper extremity/arm] Type: PICC Lumens [extensions]: 2. Record review of Resident 36's physician's order, dated 01/06/2026, documented, IV Dressing Change - PICC every day shift every Sun [Sunday] for PICC Maintenance Measure upper arm circumference and external catheter length on admission and with each dressing change. Record review of Resident 36's EHR did not show documentation of left upper extremity measurements or external catheter length was documented on admission or with the dressing change that was documented on Sunday 01/11/2026. Record review of Resident 36's EHR did not show documentation of dressing change completion that was scheduled for Sunday 01/18/2026. In an interview on, 01/22/2026 at 2:42 PM, Staff F, UM/LPN, said it was the expectation that Resident 36's PICC line dressing change would have been completed and documented per physicians' orders. Staff F reviewed Resident 36's Treatment Administration Record and stated, shows it was not documented on the 18th. When asked when Resident 36's PICC line dressing was last changed Staff F stated, it was documented on 01/11/2026. Staff F reviewed Resident 36's EHR but was unable to find documentation of PICC line catheter or left upper arm measurements on admission [DATE] or scheduled dressing changes on 01/11/2026, and 01/18/2026. Insulin orders Record review of Resident 36's physician's order, dated 01/06/2026, documented, Check Blood Sugar. Notify physician if CBG [Capillary Blood Glucose, blood glucose level] results is less than 70 or more than 400. before meals and at bedtime. Record review of Resident 36's physician's order, dated 01/06/2026, documented, If CBG is below 70 and resident is able to swallow: administer 15-20 grams of fast acting carbohydrates: 1/2 cup or 4 ounces Juice. 1 cup skim milk, 3 glucose tablets, 4 sugar cubes, 5-8 pieces of hard candy or 15-20 grams of fast acting carbohydrate: Glucose Gel (Instant Gel). If unable to swallow: give glucagon [treats low blood sugar] 1mg [milligram] subQ [subcutaneous, skins fatty layer] or IM [intramuscular, within the muscle]. Re check blood glucose approximately every 15 minutes after giving carb until 90 or above. Notify MD [medical doctor] per orders. Follow up with protein snack. Record review of Resident 36's EHR documented CBG levels of 67 on 01/14/2026 at 12:29 PM. Resident 36's EHR did not show documentation of low blood sugar interventions per physician's order. Next blood sugar was documented at 16:39 PM, four hours later. Record review of Resident 36's EHR documented CBG levels of 67 on 01/15/2026 at 8:49 AM. Resident 36's EHR did not show documentation of low blood sugar interventions per physician's order. Next blood sugar was documented at 12:55 PM, four hours later. In an interview on, 01/22/2026 at 3:13 PM, Staff F said it was the expectation that the licensed nurse should have initiated low blood sugar protocol as ordered and notified the MD of Resident 36's low (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	blood sugars on 01/14/2026 and 01/15/2026. In an interview on, 01/23/2026 at 10:20 AM, Staff B said it was her expectation that the licensed nurse followed physician's orders when checking Resident 36's blood sugar. Weights Record review of facility policy, titled, Weight Monitoring, updated 11/14/2022, documented, CNA Responsibilities 1. Weigh each resident within 24 hours of admission and readmission, preferably on the shift when the admission occurred. 2. Weigh the resident weekly for four weeks and/or until the wight is determined to be stable by the interdisciplinary team following admission and readmission. Licensed Nurse Responsibilities 1. Verify accuracy of the weight by comparing the weight with the most recently recorded weight. Record review of Resident 36's EHR documented a weight obtained on 01/08/2026 of 177.4 Lbs (pounds) two days after admission. Record review of Resident 36's EHR, on 1/22/2026, did not show additional documentation of weights. In an interview on 01/22/2026 at 2:55 PM, Staff F said residents who were new admissions to the facility were weighed weekly up to four weeks. When asked how many times Resident 36 had been weighed since admission, Staff F reviewed the EHR and said Resident 36 was weighed once. In a joint interview on 01/23/2026 at 10:40 AM, with Staff B and Staff H, Assistant Director of Nursing/RN, Staff B said residents who were new admissions were weighed per facility policy. Staff H said residents located on B side (side of the building where Resident 36 was located) were supposed to be weighed weekly. In a joint review of Resident 36's EHR, both Staff B and Staff H said one weight was documented since admission. Reference WAC 388-97-1060(1)(3)(c)

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to convey the trust account for 1 of 4 residents (Resident 107) reviewed for trust funds. This failure placed the residents and/or their representatives at risk for loss of funds. Findings included.Resident 107 admitted to the facility on [DATE]. Resident 107 had a trust account while a resident in the facility. Resident 107 expired on [DATE]. Review of the facility's Resident Statement Landscape, from [DATE] to [DATE], indicated Resident 107 had a balance of .03 cents. The account was closed on [DATE], 53 days after Resident 107 expired.During an interview on [DATE] at 10:50 AM, Staff L, Business Office Manager, said trust accounts were supposed to be conveyed no longer than 30 days after discharge or death. Staff L said she just recently closed out Resident 107's account. Reference WAC 388-97-0340 (5)

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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 and record review, the facility failed to develop a comprehensive care plan for 2 of 3 sampled residents (Resident 36 & 78) reviewed for bed rails. This failure placed residents at risk for injury and a diminished quality of life.Findings included.Record review of facility policy, titled, Safety Device Application, date revised 04/07/2023, documented, 1. Verify the following: . d. Safety device is documented on the Safety Device Care Plan.Resident 36 was admitted to the facility on [DATE]. The admission Minimum Data Set (MDS), an assessment tool, dated 01/10/2026, showed Resident 36 was moderately cognitively impaired. In an observation on 01/20/2026 at 9:44 AM, Resident 36's bed was observed with quarter length bed rails on the upper left and right sides of bed. In an observation on 01/21/2026 at 11:04 AM, Resident 36's bed was observed with quarter length bed rails on the upper left and right sides of bed. Record Review of Resident 36's Comprehensive Care Plans, initiation date 01/06/2026, did not show a Focus, Goal, or Intervention documenting Resident 36's use of bed rails.Resident 78 was admitted to the facility on [DATE]. The admission MDS, dated [DATE], showed Resident 78 was moderately cognitively impaired. In an observation on 01/20/2026 at 9:16 AM, Resident 78's bed was observed with quarter length bed rails on the upper left and right sides of bed.In an observation on 01/21/2026 at 2:08 PM, Resident 78's bed was observed with quarter length bed rail on the upper left and right side of bed.Record Review of Resident 78's Comprehensive Care Plans, initiation date 01/06/2026, did not show a Focus, Goal, or Intervention documenting Resident 78's use of bed rails.In an interview on 01/21/2026 at 2:37 PM, Staff F, Unit Manager/Licensed Practical Nurse, reviewed Resident 36's and Resident 78's electronic health record and said both Resident 36 and Resident 78 did not have care plans for bed rails and there should have been.In an interview on 01/23/2026 at 10:16 AM, Staff B, Director of Nursing/Registered Nurse, said the bed rails on Resident 36's and Resident 78's bed should have been addressed in their respective care plans. Reference WAC 388-97-1060(2)(c)

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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** Based on interview and record review, the facility failed to ensure resident care plans were revised to accurately reflect care needs for 1 of 3 sampled residents (Resident 11) reviewed for activities of daily living (ADL). This failure placed residents at risk for unmet care needs and a diminished quality of life.Findings included.Resident 11 was admitted to the facility on [DATE] with multiple diagnosis to include diabetes mellitus (DM, a disease in which the body's ability to produce or respond to the hormone insulin is impaired resulting in elevated blood sugar levels). The Quarterly Minimum Data Set, an assessment tool, dated 11/07/2025, documented Resident 11 was cognitively intact and had diabetes mellitus. Record review of Resident 11's physician orders, dated 08/04/2023, documented, Diabetic Nail Care every day shift every Sat [Saturday] for DM LN [Licensed Nurse] to do nail care.Record review of Resident 11's ADL care plan, revised on 02/20/2025, showed an intervention, Bathing: Clean and trim nails on bath day and as necessary. Trimming to be done by CNA [Certified Nursing Assistant]. Record review of Resident 11's Kardex (a nursing documentation system used to provide a quick summary of patient care needs), dated 01/22/2026, documented, .BATHING: Clean and trim nails on bath day and as necessary. Trimming to be done by CNA .In an interview on 01/22/2026 at 3:08 PM, Staff E, CNA, said they got information on care needs for residents, such as bathing and ADLs, from the Kardex. In an interview on 01/22/2026 at 3:32 PM, Staff D, Unit Manager/Licensed Practical Nurse, said CNAs did not do nail care for diabetic residents, nurses only did diabetic nail care. After looking at Resident 11's care plan, Staff D said Resident 11's ADL care plan should have been updated for the nurse to do nail care.In an interview on 01/23/2026 with Staff C, Regional Administrator, and Staff B, Director of Nursing/Registered Nurse, Staff B said the care plan populated the Kardex. Staff B said Resident 11's care plan should not have had the CNA's do nail care; it should have been the nurse. Reference WAC 388-97-1020 (5)(b)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide oxygen humidification (providing warm and moistened oxygen with water vapor preventing dryness, sore throats, and thickened mucus caused by long-term use of dry oxygen) for 1 of 2 residents (Resident 78) reviewed for respiratory care. This failure placed residents at risk of respiratory complications and a diminished quality of life. Findings included.Resident 78 was admitted to the facility on [DATE] with diagnosis including malignant pleural effusion (excessive fluid build up in the lungs caused by cancer cells). The admission Minimum Data Set, an assessment tool, dated 01/11/2026, showed resident 78 was moderately cognitively impaired. Record review of Resident 78's physician's order, dated 01/09/2026, documented, O2 [oxygen] @[at] 2 Liters via Nasal Cannula w[with]/ humidification to keep O2 sats >[greater then] 90%[percent] and/or SOB[shortness of breath]/Comfort every shift for Respiratory failure w/hypoxia [low oxygen].Record Review of Resident 78's January 2026 electronic treatment record showed licensed nurses documented oxygen was administered with humidification.In an observation on 01/20/2026 at 9:16 AM, Resident 78 was observed lying in bed with oxygen via nasal cannula delivered through an oxygen concentrator (machine that delivers oxygen) which did not have a humidifier connected to it. In an observation on 01/21/2026 at 2:08 PM, Resident 78 was lying in bed with oxygen via nasal cannula delivered through an oxygen concentrator which did not have a humidifier connected to it.In an interview on 01/21/2026 at 2:30 PM, Staff F, Unit Manager/Licensed Practical Nurse reviewed Resident 78's physician orders for oxygen use. Staff F said Resident 78's oxygen concentrator should have had humidification per the physician's order. Reference WAC 388-97-1060 (1)(3)(vi)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to obtain a bed rail physician's order, use of bed rail consent, and evaluation for 2 of 3 sampled residents (Resident 36 & 78) reviewed for accidents. This failure placed residents at risk of injury and a diminished quality of life. Findings included.Record review of facility policy, titled, Safety Device Application, date revised 04/07/2023, documented, 1. Verify the following: a. Safety Device Data Collection completed and evaluated for the need of a safety device.b. Physician's order obtained for safety device.c. Safety Device Data Collection, Evaluation, and Information evaluation completed and reviewed with the resident or resident representative.Resident 36 was admitted to the facility on [DATE]. The admission Minimum Data Set (MDS), an assessment tool, dated 01/10/2026, showed Resident 36 was moderately cognitively impaired. In an observation on 01/20/2026 at 9:44 AM, Resident 36's bed was observed with quarter length bed rails on the upper left and right sides of bed.In an observation on 01/21/2026 at 11:04 AM, Resident 36's bed was observed with quarter length bed rails on the upper left and right sides of bed.Record review of Resident 36's Electronic Health Record (EHR) did not show a physician's order for bedrails, nor did it show an evaluation and consent for the use of bed rails was completed.Resident 78 was admitted to the facility on [DATE]. The admission MDS, dated [DATE], showed Resident 78 was moderately cognitively impaired.In an observation on 01/20/2026 at 9:16 AM, Resident 78's bed was observed with quarter length bed rails on the upper left and right sides of bed.In an observation on 01/21/2026 at 2:08 PM, Resident 78's bed was observed with quarter length bed rail on the upper left and right side of bed.Record review of Resident 78's EHR did not show a physician's order for bedrails, nor did it show an evaluation and consent for the use of bed rails was completed. In an interview on 01/21/2026 at 2:34 PM, Staff F, Unit Manager/Licensed Practical Nurse, reviewed Resident 36's and Resident 78's EHR and said both Resident 36 and Resident 78 did not have physician's orders, evaluations or consents completed for bed rails and there should have been.In an interview on 01/23/2026 at 10:12 AM, Staff B, Director of Nursing/Registered Nurse, said it was her expectation that Resident 36 and Resident 78 had bed rail evaluations, consents and physician's orders prior to bed rails being used. Reference WAC 388-97-0260

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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** Based on observation interview and record review the facility failed to secure medications in 1 of 1 residents' room (Resident 41) reviewed for medication access and storage. This failure placed residents, staff and visitors at risk for accessing unauthorized medication, injury and a diminished quality of life. Findings included.Resident 41 was admitted to the facility on [DATE] with diagnoses to include urinary tract infection. The admission Minimum Data Set, an assessment tool, dated 12/09/2025, Showed Resident 41 was alert and oriented. In an interview and observation on 01/21/2026 at 9:46 AM, Resident 41 was observed laying in bed. Resident 41 was observed to have three bottles of medication on her bedside table. The labels/names on the on the bottles were Azo Cranberry, Centrum Women's and Azo Urinary Defense. Resident 41 stated she had been taking the medication for some time. When asked Resident 41 if staff knew she had the medications in her room, she stated I keep them there (pointing at her bedside table) so I guess they do.Record review of Resident 41's electronic health records did not show a medication self-administration assessment had been done nor a physicians order for medication self-administration.In an interview and observation on 01/21/2026 at 10:06 AM, Staff M, Registered Nurse, observed the medication bottles on Resident 41's bedside table and said residents who had their own medication would have their medications stored in the nurses medication cart after the provider reviewed the medication, gave the order and if the pharmacy did not have the medication, the resident's own medications would have a pharmacy printed label and administered per physicians order.In an interview on 01/21/2026 at 11:42 AM, Staff F, Unit Manager/Licensed Practical Nurse, stated residents should not have medication at bedside. If they choose to a self-medication assessment is completed, MD [doctor] to review medications and give order for the medication and self-administration.Reference WAC 388-97-1300(2)

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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. Based on observation, interview, and record review, the facility failed to implement appropriate infection prevention and control practices when a resident ingested a medication that fell on the floor for 1 of 2 staff observed (Staff G) for medication administration; and failed to ensure staff properly donned (putting on) personal protective equipment (PPE) for 1 of 5 sampled resident rooms (Room B33) reviewed for infection prevention and control. This failure placed residents at risk for the spread of infection transmission in the facility and a diminished quality of life.Findings Included. In an observation and interview on 01/22/2026 at 9:46 AM, Staff G, Registered Nurse (RN), was observed standing at the A wing nurse's station beside the medication cart. A resident was sitting in her wheelchair next to the nurse's station counter. Staff G was observed to set a cup of pills and a cup of water on the counter beside the resident. The resident took pills out of the cup and started to swallow them. One white pill dropped onto the floor when the resident was taking the pills. Staff G was observed to pick up the white pill off the floor and set it down on the counter one inch away from the cup of pills. The resident picked up the white pill that dropped onto the floor and swallowed it. Staff G was observed to watch the resident swallow the pill and did not say anything to the resident. When asked Staff G what the procedure was if a medication dropped onto the floor, Staff G said dropped medication should be put in the sharps container (a puncture resistant container designed for the safe disposal of needles, syringes, and other medical waste). Staff G stated, I should have put it in the sharps. In an interview on 01/22/2026 at 12:49 PM, Staff D, Unit Manager/Licensed Practical Nurse (LPN), said if a medication dropped on the floor, the nurse should destroy it and get a new one. In an interview on 01/22/2026 at 2:13 PM, Staff B, Director of Nursing/RN said she expected a medication was thrown away that fell on the floor. Review of the infection control sign titled, Contact Enteric Precaution, dated 08/03/2023, indicated, Prior to entering – wash or gel hands prior to entry. – Use SOAP AND WATER upon leaving the room. Wear a gown and gloves. During an observation on 01/22/2026 at 1:02 PM Staff J, Restorative Aide/Nursing Assistant, went into room B 33 with a lunch tray. Outside the room next to the door was a sign Contact Enteric Precaution. Staff J went into the room but did not don PPE. As Staff J left the room, Staff J used gel to sanitize his hands. During an interview on 01/22/2026 at 1:11 PM, Staff J said he only had to wear PPE if he was providing care. Staff J said he only had to sanitize his hands when leaving the room because no care was provided. Staff J said he went into the room to deliver a lunch tray to the resident in bed 1. During an interview on 01/22/2026 at 1:16 PM, Staff K, Infection Preventionist/LPN, said the expectation for staff entering rooms with the Contact Enteric Precaution signs to perform hand hygiene and don PPE. Staff K said when staff exited the room, they were supposed to wash their hands with soap and water. Reference WAC 388-97-1320 (1)(a)