STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505389	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation of Cascade Park	801 Southeast Park Crest Avenue Vancouver, WA 98683

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. (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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to obtain a Safety Device Evaluation and Consent and/or physician's order for 2 of 4 sampled residents (Resident 75 & 112) reviewed for physical restraints. This failure placed residents at risk of injury, unmet needs, and a diminished quality of life.Findings included. Record review of the facility's policy titled, Restraint and Device Guideline, undated, documented, When a safety device is determined to be needed to provide a safe environment for the resident the RCM [Resident Care Manager] or designee will:A. Complete or update the Safety Device Assessment.B. Notify the Physician of evaluation and obtain needed order.C. Notify the resident and/or Responsible Party.I. The Responsible Party may give consent over the phone.E. Initiate Care Plan and update Kardex. 1) Resident 75 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (an assessment tool), dated 09/30/2025, showed resident 75 was severely cognitively impaired. In an observation on 11/17/2025 at 2:26 PM, Resident 75's bed was observed low to the ground, about three to four inches off the floor. In an observation on 11/20/2025 at 9:08 AM, Resident 75 was observed lying in bed with the bed low to the ground, about three to four inches off the floor. In an observation on 11/20/2025 at 11:13 AM, Resident 75 was observed lying in bed with the bed low to the ground, about three to four inches off the floor. Review of Resident 75's Electronic Health Record (EHR) showed no Safety Device Evaluation and Consent, and/or physician's order, related to the bed in low position to the ground was completed. Record Review of Resident 75's Comprehensive Care Plans, initiation dated 06/24/2025, did not show a Focus, Goal, or Intervention related to the bed placed in a low position. In an interview on 11/20/2025 at 11:20 AM, Staff E, Resident Care Manger/Registered Nurse (RN) said when a resident had their bed placed in the low position or against the wall, they needed to have physician orders, evaluations and consent, and a care plan in place. In a joint observation and interview at 11/20/2025 at 11:26 AM, Staff E went to Resident 75's room and observed the bed in low position stating, Yes, I would consider that to be bed in low position. After looking at Resident 75's EHR, Staff E said there was not a physician's order, evaluation, consent, or care plan for the bed to be in low position and there should have been. 2) Resident 112 was admitted to the facility on [DATE]. Record review of Resident 112's BIMS (Brief Interview for Mental Status, a screening tool used to evaluate a resident's cognitive function and identify the presence and severity of cognitive impairment), dated 11/18/2025, showed Resident 112 was moderately cognitively impaired. In an observation on 11/17/2025 at 12:00 PM, Resident 112's left side of the bed was observed against the wall. In an observation on 11/20/2025 at 8:38 AM, Resident 112 was observed lying in bed with the left side of the bed against the wall. Review of Resident 112's Electronic Health Record (EHR) showed no Safety Device Evaluation and Consent and/or physician's order related to the bed against the wall was completed. Record Review of Resident 112's Care Plans, initiation dated, 11/12/2025, did not show a Focus, Goal, or Intervention related to the bed placed against the wall. In a joint observation and interview on 11/20/2025 at 11:44 AM, Staff E, Resident Care Manger/Registered Nurse (RN) went to Resident 112's room and observed the left side of the bed against the wall. Staff E said she did not realize the bed was against the wall. After looking at Resident 112's EHR, Staff E said there was not a physician's order, evaluation, consent, or care plan for the bed against the wall. In an interview on 11/20/2025 at 1:15 PM, Resident 112 said he felt his bed against the wall helped him from rolling out of bed on the left side. In an interview on 11/21/2025 at 10:03 AM, Resident 112 said it was a staff member that moved it against the wall when he told them he felt like he may roll out of bed on that side. In an interview on 11/21/2025 at 10:21 AM, Staff B, Director of Nursing/RN said it was her expectation an evaluation, consent, and physician's order was in place for a resident's bed against the wall and/or in low position. Reference WAC 388-97-0620 (4)(a)(b)

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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 3 of 14 sampled residents (Resident 75, 19, & 71) reviewed for physical restraints, behavior-emotional, dementia care, and unnecessary medications. This failure placed residents at risk for risk of injury, unmet care needs, and a diminished quality of life. Findings included. 1) Resident 75 was admitted to the facility on [DATE] with multiple diagnoses to include Post Traumatic Stress Disorder (PTSD, a mental health condition that can develop after a person experiences or witnesses a traumatic event.) The Quarterly Minimum Data Set (MDS, an assessment tool), dated 09/30/2025, showed resident 75 was severely cognitively impaired and had a diagnosis of PTSD. Physical Restraints In an observation on 11/17/2025 at 2:26 PM, Resident 75's bed was observed low to the ground, about three to four inches off the floor. In an observation on 11/20/2025 at 9:08 AM, Resident 75 was observed lying in bed with the bed low to the ground, about three to four inches off the floor. In an observation on 11/20/2025 at 11:13 AM, Resident 75 was observed lying in bed with the bed low to the ground, about three to four inches off the floor. Record Review of Resident 75's Comprehensive Care Plans, initiation dated 06/24/2025, did not show a Focus, Goal, or Intervention related to the bed placed in a low position. In an interview on 11/20/2025 at 11:20 AM, Staff E, Resident Care Manger/Registered Nurse (RN) said when a resident had their bed placed in the low position or against the wall, they needed to have a care plan in place. In a joint observation and interview at 11/20/2025 at 11:26 AM, Staff E went to Resident 75's room and observed the bed in low position stating, Yes, I would consider that to be bed in low position. After looking at Resident 75's Electronic Health Record (EHR), Staff E said there was not a care plan for the bed to be in low position and there should have been. In an interview on 11/21/2025 at 10:21 AM, Staff B, Director of Nursing/RN said it was her expectation a care plan was in place for a resident's bed placed in the low position. Behavioral-Emotional Record review of Resident 75's Comprehensive Care plan showed a Focus area, dated 11/15/2025, Mood/Behavior/Psychosocial Issues Cognitive impairment - Brining up past potential trauma., was initiated four months and 22 days after admission. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident 75's Comprehensive Care Plan showed a Focus area, dated 11/17/2025, Trauma: Physical, Emotional, Social Post Traumatic Stress Disorder (PTSD)., was initiated four months and 24 days after admission. Record Review of Resident 75's Comprehensive Care Plan did not show a Focus, Goal, or Intervention related to PTSD prior to 11/15/2025. In an interview on 11/21/2025 at 11:54 AM, Staff I, Social Services Director, said a resident with a diagnosis of PTSD should have a PTSD and/or trauma care plan in place upon admission. After looking at Resident 75's EHR, Staff I said Resident 75 was admitted with a diagnosis of PTSD, and stated, .No, there was no PTSD care plan in place prior to the one in there right now, earlier this week, and there should have been. In an interview on 11/21/2025 at 12:25 PM, Staff B said Resident 75 should have had a PTSD care plan in place prior to November. 2) Resident 19 was admitted to the facility on [DATE], with multiple diagnoses to include dementia (loss of brain function that includes memory and thinking abilities that are severe enough to interfere with daily life). The Significant Change MDS dated [DATE], showed Resident 19 was severely cognitively impaired and was on an antianxiety medication. Antianxiety Medication Record review of Resident 19's physician order, dated 10/18/2025, showed Resident 19 was prescribed Lorazepam (fast-acting prescription anti-anxiety medication used primarily for its calming and sedative effects) 0.5 MG (milligram) as needed for anxiety. The October and November 2025 Electronic Medication Administration Record (EMAR) showed Resident 19 was receiving lorazepam 0.5mg. Record review of Resident 19's care plan did not show a focus addressing Resident 19 having been on an antianxiety medication. In an interview on 11/20/2025 at 10:08 AM, Staff D, Resident Care Manager/Registered Nurse, said Resident 19's care plan should have included the use of antianxiety medication as of the date it was ordered on 10/18/2025. Staff D reviewed Resident 19's care plan and stated, it was initiated on the 11/19/2025, thirty-two days after the medication was ordered. In an interview on 11/20/2025 at 2:05 PM, Staff B said it was her expectation that the use of antianxiety medication care plan was in place when Resident 19 started taking antianxiety medication. Dementia Record review of Resident 19's care plan did not show a focus addressing Resident 19's diagnosis of dementia. In an interview on 11/20/2025 at 10:11 AM, Staff D, said Resident 19's care plan should have included a focus on dementia. Staff D reviewed Resident 19's care plan and stated, it's not in the care plan, referring to dementia diagnosis. (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 11/20/2025 at 2:06 PM, Staff B, said it was her expectation that Resident 19 should have had a dementia care plan. Anticoagulant Medication Resident 71 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], showed Resident 71 was moderately cognitively impaired with multiple diagnosis to include chronic atrial fibrillation (irregular heartbeat) and was on an anticoagulant (blood thinner) medication. Record review of Resident 71's physician order, dated 07/16/2025, showed Resident 71 was prescribed Dabigatran Etexilate Mesylate (anticoagulant) Oral Capsule 110 MG (Milligram) for chronic atrial fibrillation. Resident 71's EMAR from July 2025 to November 2025 showed Resident 71 was receiving Dabigatran Etexilate Mesylate Oral Capsule 110 MG. Record review of Resident 71's care plan did not show a focus addressing Resident 71 having been on an anticoagulant medication. In an interview on 11/20/2025 at 10:41 AM, Staff D said Resident 71's care plan should have included the use of an anticoagulant. Staff D reviewed Resident 71's care plan and stated, it should be included in the care plan but i don't see one, referring to the anticoagulant care plan. Reference WAC 388-97-1020(1)(2)(a)(b)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents received restorative aid (RA) services for 1 of 3 residents (Resident 8) reviewed for activities of daily living. These failures placed residents at risk for further decline and a diminished quality of life.Findings included.Review of the facility's policy titled, Restorative Services, dated 01/11/2005, showed; It is the policy of this facility to provide its residents the restorative services in an effort to maintain the residents highest level of self-care and independence. 2.Each resident in the program shall receive, including but not limited to, muscular exercises, mental stimulation and improvement in independent living activities of daily living.Resident 8 admitted to the facility on [DATE] with multiple diagnoses. Resident 8's quarterly Minimum Data Set (an assessment tool), dated 09/12/2025, indicated Resident 8 was severely cognitively impaired and showed Resident 8 had one day of Restorative Nursing Program services for range of motion during the review period. Review of Resident 8's physical therapy PT (physical therapy) Discharge Summary, service date 03/07/2025 - 04/23/2025, indicated Resident 8 required a Restorative Program Established/Trained = Other Restorative Program (RA program for sit<>stand transfers and omni cycle [a specialized, motorized therapeutic exercise system designed for medical rehabilitation] x 15 min [minutes] L1-2 [level]to maintain CLOF [current level of function]).Review of Resident 8's Therapy RA Referral Form, dated 04/23/2025, documented Restorative Nursing Plan for Rehabilitation or Restorative Techniques/Practices Active ROM [range of motion]. Transfers. 1. Repeated sit to stands in II (parallel) bars or T/F [transfer] pole 3x10 reps. 3x/week. 2. Omni cycle x15mins L1-2 3x/week. Review of Resident 8's Physical Therapy PT Discharge Summary, service date 09/15/2025-10/13/2025, documented D/C [discharge] Recs Discharge Recommendations: 24 hour care. RA program for [NAME] (lower extremity - [the legs from the hip down to the feet]) strength. Record review of Resident 8's EHR did not show documentation of Resident 8 having RA services. In an interview on 11/20/2025 at 2:39 PM, Staff G, Resident Care Manager/Restorative Therapy Manager/Registered Nurse (RN), said Resident 8 was on a feeding program but did not meet the requirements for a restorative program.In an interview on 11/21/2025 at 9:53 AM, Staff H, Director of Rehabilitation, said Resident 8 was discharged from PT on 04/23/2025 with a recommendation for a restorative program to include sit to stand, transfer pole and the Omni Cycle. Staff H said Resident 8 was picked up for PT in September 2025 related to weakness from Covid. In an interview on 11/21/2025 at 11:54 AM, Staff G said the restorative program assisted with maintaining residents' range of motion and their current strength levels. In an interview on 11/21/2025 at 1:14 PM, Staff B, Director of Nursing/RN, said the restorative program was for residents to maintain or strengthen themselves. Staff B said they were not aware of how Resident 8 was not on a restorative program. Reference WAC 388-97-1060 (1)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation, interview and record review, the facility failed to implement physician orders and/or care plans for 1 of 5 residents (Resident 71) reviewed for weights and 1 of 4 residents (Resident 112) reviewed for physical restraints. This failure placed residents at risk of injury, unmet care needs, and a diminished quality of life.Findings included . 1) Physical Restraints Resident 112 was admitted to the facility on [DATE]. Record review of Resident 112's BIMS (Brief Interview for Mental Status, a screening tool used to evaluate a resident's cognitive function and identify the presence and severity of cognitive impairment), dated 11/18/2025, showed Resident 112 was moderately cognitively impaired. Record review of Resident 112's Assistive Device care plan, dated 11/12/2025, documented, .Mobility bar/ 1/4 size side rail to right side only to assist w/ [with] stability during transfers and mobility. Resident requires assistive device d/t [due to] Gait unsteady, intermittent dizziness/vertigo w/mobility bradycardia [slow heart rate] . The Assistive Device care plan further documented interventions, dated 11/12/2025, 1/4 SIDERAILS per MD [medical doctor] order for (safety, during cares, to assist with bed mobility) Observe for entrapment/injury.Resident uses a mobility bar on bed to improve/assist with bed mobility. Record review of Resident 112's ADL (Activities of Daily Living) care plan, dated 11/12/2025, documented interventions, .BED MOBILITY: The resident uses an assistive device right side only Mobility bar/bed rail to reposition and turn in bed.POSITIONING: Side Rails Type : Mobility bar: 1/4 size side rail to right side only when transferring out of bed, into bed, repositioning in bed, turning side to side in bed.TRANSFER: The resident uses right sided only mobility bar/bed rail and FWW for assistive device to transfer. Record review of Resident 112's physician orders, dated 11/14/2025, documented, 1/4 side rail to the right side-consent signed. In an observation on 11/17/2025 at 12:00 PM, Resident 112's left side of the bed was observed against the wall with no side rails or mobility bars on the bed. In an observation on 11/20/2025 at 8:38 AM, Resident 112 was observed lying in bed with the left side of the bed against the wall with no side rails or mobility bars on the bed. In a joint observation and interview on 11/20/2025 at 11:44 AM, Staff E, Resident Care Manger/Registered Nurse (RN) went to Resident 112's room and observed the bed with no side rails, and the left side of the bed against the wall. After looking at Resident 112's Electronic Health Record (EHR), Staff E said there was a physician's order, care plan, and consent for a side rail to be on Resident 112's bed and there was not one. Staff E said Resident 112 should have had a side rail on his bed, stating, They never put one on. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 11/20/2025 at 1:15 PM, Resident 112 said he did not have a rail on his bed since he was admitted . In an interview on 11/21/2025 at 10:21 AM, Staff B, Director of Nursing/RN, said it was her expectation if there was a physician order and care plan for a bed rail, it was on the bed. 2) Weights Resident 71 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (an assessment tool), dated 11/10/2025, showed Resident 71 was moderately cognitively impaired with multiple diagnosis to include congestive heart failure (a weakened heart condition that causes fluid buildup in the feet, arms, lungs, and other organs). Record review of Resident 71's physician order, dated 07/16/2025, showed Daily Weights: Notify MD (medical doctor) weight gain of 2 pounds per day for two consecutive Days or 5 pounds in a week. every day shift. Record review of Resident 71's daily weights for November 2025 showed weights increased on the following dates with no MD notification documented: 11/04/2025 430.6 Lbs (Pounds) and 11/05/2025 440.6 Lbs = 10 Lbs weight gain. 11/10/2025 439.1 Lbs and 11/11/2025 442.8 Lbs = 3.7 Lbs weight gain and 11/12/2025 445.4 Lbs = 2.6 Lbs weight gain. 11/15/2025 435.0 Lbs and 11/16/2025 447.4 Lbs = 12.4 Lbs weight gain and 11/17/2025 452.4 Lbs = 5 Lbs weight gain. Record review of Resident 71's weight in October 2025, showed the facility failed to obtain weights on 10/05/2025, 10/06/2025, and from 10/11/2025 to 10/16/2025, for a total of eight days. Record review of Resident 71's weight in September 2025, showed the facility failed to obtain weights from 09/01/2025 to 09/03/2025, 09/11/2025 to 09/17/2025, and 09/22/2025 to 09/26/2025 for a total of 15 days. Record review of Resident 71's weight in August 2025, showed the facility failed to obtain weights from 08/22/2025 to 08/28/2025 and 08/30/2025 for a total of eight days. In an interview on 11/20/2025 at 10:37 AM, Staff D, Resident Care Manager/Registered Nurse, reviewed Resident 71's EHR but was unable to show documentation of MD notifications of Resident 71's weight increase. In an interview on 11/20/2025 at 2:17 PM, Staff B said it was her expectation that Resident 71's weights were obtained as ordered and any increase in weight reported to the provider per physician's orders. Staff B reviewed Resident 71's EHR but was unable to show documentation of MD notification of Resident 71's weight increase. Reference WAC 388-97-1060 (1)(3)(m)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on interview and record review, the facility failed to ensure nursing hours were accurately posted and/or updated daily for 31 of 31 days reviewed for nurse staff postings. This failure placed residents, resident representatives, and visitors at risk of not being fully informed of the current staffing levels and census information.Findings Included.Record review of the Daily Staffing Hours postings, prior to being edited, from 10/18/2025 to 11/17/2025 were not provided for review. Review of the Daily Staffing Hours postings provided by the facility, from 10/18/2025 to 11/17/2025, showed changes for every day to columns titled Actual Number of staff, and/or Actual Total Hours daily.In an interview on 11/20/2025 at 8:44 AM with Staff F, Staffing Coordinator, and Staff B, Director of Nursing/Registered Nurse, Staff F said she did not update the staffing number and hours for each shift on the posted Daily Staffing Hours throughout the day when there were changes. Staff F said she took down the postings and updated them the next morning with staffing changes from the previous day. Staff F said she did not know they had to be updated with changes and did not update them until the next day after she took them down. Staff B said they were not doing the daily postings correctly and indicated they should be updated throughout the day to reflect current staffing. In an interview and record review on 11/21/2025 9:47 AM, Staff F looked at the Daily Staffing Hours postings provided, dated 10/18/2025 to 11/17/2025, and said the copies she provided were the ones that had already been corrected the next day after taken down. Staff F said they were not updated throughout the day. No WAC Reference

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to monitor for adverse side effects for antianxiety medication (fast-acting prescription medication used primarily for its calming and sedative effects) for 1 of 5 residents (Resident 19) reviewed for unnecessary medication. This failure placed residents at risk for experiencing side effects and a diminished quality of life.Findings included .Resident 19 was admitted to the facility on [DATE], with multiple diagnoses to include Dementia (loss of brain function that includes memory and thinking abilities that are severe enough to interfere with daily life). The Significant Change Minimum Data Set (an assessment tool) dated 10/21/2025, showed Resident 19 was severely cognitively impaired and was on an antianxiety medication.Record review of Resident 19's physician order, dated 10/18/2025, showed Resident 19 was prescribed Lorazepam 0.5mg (milligram) as needed for anxiety. The October and November 2025 electronic medication administration record showed Resident 19 was receiving lorazepam 0. 5mg but there was no documentation of monitoring for adverse side effects.In an interview on 11/20/2025 at 10:05 AM, Staff D, Resident Care Manager/Registered Nurse, said it was the expectation that Resident 19 was monitored for adverse side effects while receiving Lorazepam. Staff D reviewed Resident 19's electronic health record and stated, the order was placed on 11/19/2025, 32 days after the medication was ordered.In an interview on 11/20/2025 at 2:05 PM, Staff B, Director of Nursing/Registered Nurse, said it was her expectation that while receiving antianxiety medication, Resident 19 was monitored for adverse side effects. Reference WAC 388-97-1060(4)

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	505389	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation of Cascade Park	801 Southeast Park Crest Avenue Vancouver, WA 98683

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 use personal protective equipment (PPE, gloves, gown and/or mask) on 1 of 1 resident (Resident 11) reviewed for transmission-based precautions (infection control measures). This failure placed residents at risk of infection transmission and a diminished quality of life.Findings included .Resident 11 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (an assessment tool) dated 8/30/2025, showed Resident 11 was alert and oriented and was dependent on staff for transfers using a Hoyer (mechanical) lift.Record review of Resident 11's physician order, dated 11/18/2028, showed Resident 11 was on contact precautions (measures that are intended to prevent transmission of infectious agents).In an observation on 11/21/2025 at 8:58 AM, Staff J, Certified Nurse Assistant (CNA) was observed transferring Resident 11 from her bed to a stretcher without wearing an isolation gown. Staff K, CNA, was observed assisting Staff J to transfer Resident 11 but did not wear an isolation gown.In an interview on 11/21/2025 at 1:46 PM, Staff B, Director of Nursing/Registered Nurse, said it would be the expectation that staff wear PPE when transferring residents on contact precautions. Reference WAC 388-97-1320