

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505409	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2026
NAME OF PROVIDER OR SUPPLIER Summitview Rehab and Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3801 Summitview Avenue Yakima, WA 98902	
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide dignified care in a manner and in an environment that enhanced dignity and quality of life for 4 of 6 residents (Residents 2, 5, 7 and 28) reviewed for dignity. This failure placed residents at risk for unmet needs and a poor quality of life. Findings included. Record review of a facility policy titled, Dignity, dated 02/2021 showed .Residents are always treated with respect and dignity.Residents are provided with a dignified dining experience.Staff protect confidential clinical information, and verbal communication is kept outside the hearing of other residents or the public. Resident 2 Review of the resident's medical record showed they were admitted to the facility with diagnoses which included a history of stroke (blood flow to the brain is blocked causing lack of oxygen to brain tissue), dementia (a decline in mental ability that interferes with daily life) and depression. The comprehensive assessment dated [DATE] showed the resident had moderate cognitive impairment, required substantial assistance from staff for dressing and grooming and was dependent on staff for transfers and mobility. During an observation on 05/18/2026 at 11:54 AM, Resident 2 was in the dining room sitting at a table with two other residents waiting for their lunch meal. The dining room had 19 total residents seated at various tables also waiting for their meals. Additionally, there was a family member sitting with their mother. A visitor entered the dining room with an open computer and approached Resident 2 while they were seated at their table. The visitor identified themselves as a Hospice nurse and the reason for their visit was because Resident 2 had a telehealth appointment with the Hospice physician. The visitor stated to the resident they were scheduled to have a meeting with the physician. The visitor placed their computer monitor in front of Resident 2 and proceeded to discuss the resident's Hospice status with the resident and the physician via computer monitor. The confidential conversation could be overheard by other residents, staff and the family member of another resident who were present in the dining room. Resident 5 (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's medical record showed they were admitted with diagnoses which included a left hip fracture and a urinary tract infection. The comprehensive assessment dated [DATE] showed they were cognitively intact, required only set up assistance for grooming and were independent with transfers and ambulation for short distances. In an observation on 05/18/2026 at 12:35 PM, Resident 5 was seated at a table with three other residents who had been served their lunch meal and had begun eating. Resident 5 had a cup of tea and was fiddling with the tea bag looking down while the other residents ate. At 12:46 PM Resident 5 was served their meal tray, 11 minutes after the other residents had been served. Resident 7 Review of the resident's medical records showed they were admitted with diagnoses which included Alzheimer's disease (a progressive brain disorder that destroys memory and thinking skills) and epilepsy (a brain condition that causes repeated seizures). The comprehensive assessment dated [DATE] showed Resident 7 was severely cognitively impaired and required total assistance from staff for dressing, grooming, eating, mobility and transfers. During an observation on 05/20/2026 at 12:03 PM, Resident 7 was seated at a table with two other residents who had received their lunch meal trays and were being assisted with eating by staff. Resident 7 did not get their meal tray until 12:17 PM, 14 minutes after the other residents had been served and were eating. During an observation on 05/20/2026 at 12:04 PM, Resident 5 was sitting at their table waiting for their meal tray as their two tablemates had already been served and were eating. At 12:16 PM Resident 5 received their meal tray, 12 minutes after the other residents had been served and began eating. During an interview on 05/22/2026 at 8:33 AM, Resident 5 stated their meal trays were usually late, they were not sure why, but kept themselves busy while the others were eating. During an interview on 05/21/2026 at 9:02 AM, Staff B, Director of Nursing Services stated they expected staff to serve residents one table at a time so other residents did not have to watch their tablemates eat in front of them as this was not dignified. Additionally, Staff B expressed concern for Resident 2's confidential health information being discussed in the dining room in a telehealth meeting in front of other residents, staff and family members as this is not allowed in the dining room. Resident 28 Review of the medical record showed the resident was admitted to the facility on [DATE], with diagnoses including a stroke with right side weakness, dementia, blindness, falls and hearing (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	impairment. The 03/03/2026 quarterly assessment showed the resident was alert, oriented and able to make their needs known. Resident 28 required set up with their meals and information where the utensils, plate, cups and food location in front of them, but were able to eat by themselves. The resident required assistance to ambulate and transfer. Resident 28s preference was to stay in their room for all activities. During an observation on 05/21/2026 at 9:35 AM, showed a nurse take a report from a nursing student that Resident 28 told them a Nursing Assistant (NA) was rude to them. During an interview on 05/21/2026 at 10:30 AM, Resident 28 stated that they could not identify the staff, but the staff was rude and should not work with the elderly. Resident 28 asked the staff member if they could assist them with eating, but the staff stated they had been busy and if the resident needed help, they could take them to the dining room. Resident 28 stated the staff repeated that they could take them to the dining room and this upset the resident further. Resident 28 stated they preferred not to leave their room due to being self-conscious of their inability to see and felt safe in their room. During an interview on 05/22/2026 at 9:50 AM, Staff I, NA, stated Resident 28 did not like to get up before 9:00 AM and the resident could feed themselves after setup. Staff I stated on the morning of 05/21/2026, they brought Resident 28's meal tray into the room. Staff I then told the resident what the meal was and location of the food. Resident 28 began eating their oatmeal and Staff I left the room. Staff I stated the resident used their call light after they had left the room. Staff I stated when they answered the resident's call light they requested assistance with eating Staff I informed the resident if they needed more assistance they could take them to the dining room. Review of the 05/22/2026 investigation by the facility showed that Staff I had acted undignified to Resident 28 by suggesting taking the resident to the dining room. Reference: WAC 388-97-0180(1)-(4)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident's Power of Attorney (POA), was fully informed of the admission agreement to include payment for services and co-payment requirements for 1 of 3 residents (Resident 43) reviewed for admission to the facility. This failure placed the resident/POA at risk for the inability to make informed decisions regarding the resident's health care, alternative treatments and the right to refuse care/services. Findings included. Resident 43 Review of the medical record showed the resident was admitted to the facility on [DATE] with a post-operative diagnosis of a fractured left shoulder with a shoulder joint replacement. Other diagnoses included depression and delirium (a state of confusion, memory issues related to a medical or psychological condition). The 05/05/2026 nursing admission assessment showed the resident had cognitive impairment and required assistance with Activities of Daily Living (ADL) for transfers. Review of the 05/04/2026 Social Service History and Initial Assessment showed that under section B, the advanced care planning, Resident 43 stated they had a POA for Health and Financial authority and would ask someone to bring a copy. During an interview on 05/18/2026 at 11:00 AM, Collateral Contact 1 (CC1), POA stated they had not received any paperwork on Resident 43's admission process or any information regarding what the resident's insurance covered. During an interview on 05/18/2026 at 11:30 AM with Staff E, [NAME] Coordinator and Staff H a second [NAME] Coordinator, it was stated that Staff H had reviewed the admission paperwork with Resident 43. Staff H stated that they asked Resident 43's visitor (a family member visiting with Resident 43, not their POA) about going over paperwork and if the resident could fill it out. The visitor asked Staff H to come back later. Staff H came back later and had the resident sign paperwork. Staff H was unaware that the resident had a POA who was responsible for their finance and healthcare. Staff H had not contacted or asked for their POA document. Record review of Resident 43's paperwork showed they were admitted to the facility on [DATE] and had a co-pay that would start on the 20th day, 05/20/2026, at \$217 a day. Currently, Resident 43 was on the 19th day of their stay at the facility. During an interview on 05/18/2026 at 12:15 PM, CC1, POA stated they were unaware of the upcoming \$ 217 a day charge starting on 05/20/2026 for Resident 43's stay on the 21st day. Additionally, CC1stated they were not asked to bring the durable power of attorney paperwork. During the interview with the POA and Resident 43, the resident stated they did not recall reviewing or signing the admission paperwork. During an interview on 05/18/2026 at 2:00 PM, Staff D, Social Services Director, stated a social service admission review was completed on 05/04/2026 with Resident 43. Staff D stated there was no follow up on obtaining a copy of the POA. Reference: WAC 388-97-0260 and WAC 388-97-0240		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a Preadmission Screening and Resident Review (PASARR, a process to determine if a potential nursing home resident had a serious mental illness [SMI] or intellectual disability needs which required further assessment/treatment) had the required Level 2 PASARR referral sent when a resident had a positive Level 1 PASARR and was in the facility more than 30 days for 1 of 7 residents (Resident 10) reviewed for PASARR. This failure placed the residents at risk for inappropriate nursing home placement and/or not receiving timely and necessary services to meet their mental health needs. Findings included. Review of the medical record showed Resident 10 was admitted to the facility on [DATE] with diagnoses including Parkinson's disease (a progressive brain disorder that affects movement and balance), syncopal episodes (fainting or a loss of blood flow to the brain leading to loss of consciousness) and depression. The 04/09/2026 comprehensive assessment showed the resident was cognitively intact and able to make their needs known. Review of Resident 10's PASARR Level 1 form completed on 04/07/2026, showed Resident 10 had a positive SMI indicator of depression but did not have a Level 2 referral sent. The document showed that Resident 10 was expected to be discharged from the facility within 30 days and met the requirements for an exempt hospital discharge (a process that required a Level 2 be sent if a resident was not going to be discharged from a facility within 30 days). During an interview on 05/20/2026 at 2:50 PM an additional PASARR for Resident 10 was requested from the facility since no other PASARR document was noted in the resident's chart. Staff D, Social Services Director, stated they would look for another PASARR for Resident 10. Review of an additional PASARR Level 1 form completed by Staff D on 05/11/2026, showed the resident was positive for a SMI and a Level 2 referral would need to be sent (completed four days after the required 30-day mark). During an interview on 05/21/2026 at 10:30 AM, Staff D stated the process for ensuring PASARR's were completed/accurate included screening the resident on admission and if the Level 1 PASARR was positive, a referral for a Level 2 evaluation (an in-depth, person-centered evaluation triggered by a positive Level 1 screen to determine if an individual required specialized services) was sent. If the resident had a SMI diagnosis, a Level 2 referral would be required prior to the residents admission, but if a resident was approved for an exempted hospital discharge, the facility would then need to screen the resident and send a referral if they were going to be admitted to the facility longer than the 30 days. Staff D stated that Resident 10 had an exempted hospital discharge and their PASARR Level 1 screening should have been completed the week before the resident's 30-day mark. Staff D stated the Level 1 PASARR form was completed on 05/11/2026 but the Level 2 referral was not sent until 05/20/2026 (13 days after the required date). Staff D stated the correct process was not followed for Resident 10's PASARR referral. During an interview on 05/21/2026 at 10:58 AM, Staff A, Administrator, stated they would have expected Resident 10's Level 1 PASARR screening and referral to have been completed/sent with the required 30 days of an exempt hospital discharge. Staff A stated the correct process was not followed. Reference: WAC 388-97-1915(1)(2)(a)(b)(c)		

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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 implement documentation/monitoring of depression symptoms per the comprehensive resident centered care plan and honor resident preferences with nighttime routines for 1 of 6 residents (Resident 38) reviewed for care plan implementation. This failure placed residents at risk for unidentified mental health symptoms and unmet care needs. Findings included .Review of the medical record showed Resident 38 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of a fracture to the left leg, respiratory failure (occurs when the lungs fail to provide adequate oxygen to the rest of the body), lung infection and protein calorie malnutrition (a form of undernutrition, caused by not eating enough protein/calories, leading to muscle/fat loss and impaired bodily functions). The 04/23/2026 comprehensive evaluation showed the resident was cognitively intact, able to make their needs known and required assistance from one to two staff with activities of daily living (the basic self-care tasks needed to maintain your health and well-being). Additionally, within the comprehensive evaluation Resident 38's mental health screening assessment showed they met criteria of moderately severe depression (a mood disorder that causes a persistent feeling of sadness and loss of interest in things and activities you once enjoyed). A concurrent observation and interview on 05/18/2026 at 2:13 PM, showed Resident 38 sitting up in bed with downward turned lips and watery/glossy eyes and on the verge of crying when conversing with the surveyor. Resident 38 proceeded to convey a list of unfortunate and sorrowful (full of or feeling sad) events they were going through, from the loss of a family member to losing their home, lots of bad things that are happening. Additionally, the resident stated that a Nursing Assistant (NA) had come into the resident's room during the night shift on 05/16/2026 and woke them up to turn and change the resident's brief, they know not to wake me up in the middle of the night. Review of Resident 38's care plan showed that on 04/28/2026 the resident was very tearful and a focus had been developed related to the resident's depression on admission due to their realization of knowing they would have to sell their home and the loss of their independence. The developed intervention was to monitor/document in the resident record signs/symptoms of depression, including sadness, anxiety, negative statements, and tearfulness. Additionally, the care plan showed the resident needed assistance from staff on repositioning in bed and was on a turning schedule to be turned every two hours while the resident was awake. The 05/07/2026 intervention specified the resident did not want to be woken up during the night shift for turning. During an interview on 05/20/2026 at 12:09 PM, Staff K, NA, stated they had known about some of Resident 38's unfortunate sorrowful events like the recent loss of the resident's family member. Staff K stated the resident's mood had been different since that had happened. During an interview on 05/21/2026 at 8:28 AM, Staff L, Licensed Practical Nurse (LPN), stated the resident had been tearful, but thought it might have been due to the resident's pain. Staff L stated that Resident 38 had conveyed some of the unfortunate/sorrowful events to the staff member before. During an interview on 05/21/2026 at 12:25 PM, Staff G, Registered Nurse/Resident Care Manager, stated they were familiar with Resident 38, and the resident had a list of unfortunate/sorrowful events with a family member passing away to cancer, a friend requiring brain surgery and the residents dog getting sick. Staff G stated that Resident 38 had depressive symptoms/statements since they were admitted and nursing staff should be monitoring/documenting them in the resident's record for the provider to see. When Staff G was reviewing Resident 38's records with the surveyor, Staff G stated they did not see documentation on the resident's depressive symptom monitoring after being developed in the care plan until 05/20/2026. Staff G stated the correct process was not being followed and the documentation of depressive symptom monitoring should have begun immediately after Resident 38's care plan was developed. During an interview on 05/21/2026 at 1:49 PM, Staff M, NA, stated they (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were familiar with Resident 38 and had taken care of them before. Staff M stated the resident was cognitively intact, utilized the call light to notify staff of needs and would inform nursing staff if the resident needed to have a brief change. Staff M stated it was known that the resident was not to be woken up at night for cares. Review of the facility's call light audits for 05/16/2026 and 05/17/2026 showed Resident 38 did not put on their call light for staff assistance during the nighttime. During an interview on 05/21/2026 at 3:27 PM, Staff C, Assistant Director of Nursing Services, stated they had investigated the NA coming into the resident's room during the night shift and performed a brief change with Resident 38. Staff C stated they were unsure why the NA was turning/changing the resident's brief when the resident was care planned to not be woken up at night. During an interview on 05/22/2026 at 7:21 AM, Staff A, Administrator, stated that Resident 38 should have been monitored for depressive symptoms/statements after it was identified and developed in the resident's care plan on 04/27/2026. Staff A stated they were not sure the night shift NA staff member knew Resident 38 did not want to be woken at night to be turned/changed. Staff A stated that Resident 38 was able to utilize the call light to notify nighttime staff if they needed assistance with a brief change. Staff A stated the correct process with implementing Resident 38's care plan was not being followed. Reference: WAC 388-97-1020(2)(a)(3)		

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the nature/terms of entering into a binding arbitration agreement (an alternative means of settling disputes through a third party arbitrator, instead of traditional court/judicial systems) were explained to residents in a form and manner in which they could understand for 2 of 5 residents (Resident 11 and 5) reviewed for arbitration. This failure placed the residents at risk for a lack of understanding concerning the legal contract that had been signed/entered into and being fully informed regarding their choice in the event of a dispute with the facility. Findings included. Resident 11 Review of the medical record showed the resident was admitted to the facility on [DATE] with diagnosis including multiple respiratory complications, stroke (a complication when blood supply to the brain is blocked or reduced which can lead to brain damage), altered mental status (a change in mental function from various illnesses, disorders, or injuries affecting the brain), and dementia (the loss of cognitive functioning, thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities). The 04/07/2026 comprehensive assessment showed the resident had severely impaired cognition, had difficulty communicating but was able to make their needs known. Record review of Resident 11's arbitration agreement showed the resident had signed the legal document themselves on 04/09/2026 consenting to the arbitration agreement. Staff H, [NAME] Coordinator, signed the arbitration agreement as the facility's representative on 04/09/2026. During an interview on 05/21/2026 at 9:01 AM, Resident 11 stated they were unaware of what arbitration was and did not remember signing the arbitration agreement, I signed a lot of things that day. After explaining arbitration, Resident 11 stated they did not want or consent to the arbitration agreement and they were not aware that it was voluntary nor that they could rescind the document within 30 days of signing it. Resident 5 Review of the medical record showed the resident was admitted to the facility on [DATE] with diagnosis including heart complications, and a bone fracture of the left leg/lower back. The 04/03/2026 comprehensive assessment showed the resident was cognitively intact and able to make their needs known. Record review of Resident 5's arbitration agreement showed the resident had signed the legal document themselves on 04/09/2026 consenting to the arbitration agreement. Staff H signed the arbitration agreement as the facility's representative on 04/09/2026. During an interview on 05/20/2026 at 11:27AM, Resident 5 and their family were visiting in the resident's room. Resident 5 stated they were unaware of what arbitration was or that they had signed/consented to the arbitration agreement, I do not like that. The resident stated their family was not present for the admission paperwork signing and the facility staff did not explain the arbitration agreement form or what it entailed. Resident 5 stated they did not know of the agreement being voluntary and not a requirement to sign, I just signed it (as in signing all the admission forms). During an interview on 05/21/2026 at 9:14 AM, Staff E, [NAME] Coordinator, stated they and Staff H both were charged with going over admission paperwork and arbitration agreements with residents and/or their representatives. Staff E stated they had recently implemented the arbitration agreements in the facility and it was the last thing that was reviewed in the admission paperwork. Staff E stated they do not go into great detail with the arbitration form explanation and that residents have the option to consent to the document or not. Staff E stated that they usually went over the arbitration agreement forms with the family and had not completed it with many residents. Staff E stated that Staff H was often the one to go through the admission and arbitration documents with facility residents. During an interview on 05/21/2026 at 9:56 AM, Staff H stated they were new to the position and had just started going through the admissions/arbitration documents with residents. Staff H stated they inform the residents of the document being a standard arbitration, voluntary to sign and that the resident can rescind the document within 30 days. Staff H stated, I do not read through it verbatim (continued on next page)		

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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 ensure infection control interventions intended to mitigate the risk for transmission of infections were consistently implemented in the areas of hand hygiene (HH) for 1 of 2 dining rooms (DR 1 and Transmission Based Precautions (TBP) specialized infection control measures used in health care settings alongside basic standard precautions) for 1 of 2 residents (Resident 12) reviewed for infection control practices. This failure placed the residents at risk for transmission of communicable diseases, and illness. Findings included. Hand Hygiene During an observation on 05/18/2026 at 11:36 AM, Staff P, Dietary, was in DR 1 with gloves on. Staff P touched resident wheelchairs to assist them to their tables, repositioned them, placed shirt protectors on the residents and touched multiple surfaces. Staff P, without performing HH or changing their gloves, proceeded to make drinks and serve them to the residents who were seated in the dining room. During an observation on 05/18/2026 at 11:46 AM, Staff P, still wearing the same contaminated gloves, assisted the meal server by obtaining food items and placing them on resident meal trays as they were prepared to be served to the residents. Transmission Based Precautions Resident 12 Review of the resident's medical record showed they were admitted with diagnoses which included pneumonia (an infection in the lungs), chronic respiratory failure (the respiratory system struggles to adequately exchange oxygen) and atrial fibrillation (an irregular heart rate). The 04/03/2026 comprehensive assessment showed the resident was cognitively intact and required substantial assistance from staff for dressing, toileting and bed mobility. Observations on 05/18/2026 at 10:21 AM, showed Resident 12's room with a sign posted outside that identified the room as Contact Precautions (a type of TBP with infection control measures that are used to prevent the spread of disease that are transmitted by direct or indirect contact with the residents or items in their environment). The sign had instructions to perform HH or use hand gel, wear a gown and gloves prior to entering the room and use only equipment dedicated to the room or disposable equipment. Observations on 05/19/2026 at 9:13 AM showed Staff Q, Physical Therapist, had entered Resident 12's room. They did not perform HH or put on a gown or gloves as directed by the contact precautions sign Staff Q brought Resident 12 into the hallway to ambulate with their contaminated walker and with no gown or gloves on them which had the potential to spread infection outside of their room. During a concurrent observation and interview on 05/19/2026 at 10:38 AM, Staff N, Licensed Practical Nurse, stated that there were no residents who were currently on contact precautions in the facility. Staff N, who was standing in the hall outside of Resident 12's room observed the contact precautions sign posted and stated they had been unaware that Resident 12 was on contact precautions and had been going in and out of the room without wearing a gown or gloves. During an interview on 05/22/2026 at 11:04 AM, Staff O, Infection Preventionist, stated Resident 12 had been placed on contact precautions related to a positive wound culture, however had not been placed on an antibiotic (a powerful medication used to treat bacterial infections) and had no acute infection symptoms. Staff O stated Resident 12 should not have been on contact precautions as it had not been necessary. Staff O further stated staff still should have followed the directions for contact precautions as posted on Resident 12's door. During an interview on 05/22/2026 at 11:16 AM, Staff B, Director of Nursing Services, stated they would have expected all staff to follow any TBP signs posted outside of resident rooms and would be ensuring some additional training on TBP, specifically contact precautions, was completed. Reference: WAC 388-97-1620(2)(b)(i)(ii)		