

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/13/2024
NAME OF PROVIDER OR SUPPLIER Sharon Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1509 Harrison Avenue Centralia, WA 98531	

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)
<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46751</p> <p>Based on interview and record review, the facility failed to provide and/or have procedures in place to assist with completing advance directives (AD), and obtaining and maintaining Durable Power of Attorney (DPOA) documentation for 4 of 9 sampled residents (1, 24, 26 & 30) reviewed for ADs. This failure place residents at risk for losing their right to have healthcare preferences and decisions honored and a diminished quality of life.</p> <p>Findings included .</p> <p>The facility's policy entitled, Advanced Directives, dated 08/01/2018, indicated, I. Upon admission, we will determine whether a resident has an advance directive, if they do not have and advance directive we will determine whether the residents or resident representative wishes to formulate and advanced directive. II. Information will be provided to the residents or resident representative about the right to refuse medical and surgical treatment and formulate an advanced directive. Including the facility policy on advance directive and applicable state law regarding advanced directives.</p> <p>1) Resident 1 was admitted to the facility on [DATE]. The quarterly Minimum Data Set (MDS) assessment, dated 07/01/2024, showed Resident 1 was severely cognitively impaired.</p> <p>Resident 1's electronic health record (EHR) did not show an AD or documentation an AD was reviewed since admission.</p> <p>2) Resident 24 was admitted to the facility on [DATE]. The admission MDS, dated [DATE], showed Resident 24 was moderately cognitively impaired.</p> <p>Resident 24's EHR did not show an AD or documentation an AD was reviewed since admission.</p> <p>3) Resident 26 was admitted to the facility on [DATE]. The 5-day MDS, dated [DATE], showed Resident 26 was alert and oriented.</p> <p>Resident 26's EHR did not show an AD or documentation an AD was reviewed since admission.</p> <p>4) Resident 30 was admitted to the facility on [DATE]. The admission MDS, dated [DATE], showed the Resident 30 was alert and oriented.</p> <p>(continued on next page)</p>

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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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident 30's EHR did not show an AD or documentation an AD was reviewed since admission.</p> <p>On 09/11/2024 at 12:23 PM, Staff K, Social Services Director, said Advance Directives were addressed in the initial admission care conference, and if residents decline, I typically make a note in the care conference. I Follow up. I reach out. If they don't have it, I give them a form to fill out. Staff K said there had been gaps in documentation. Staff K stated, I could probably be better with follow up. It should be documented.</p> <p>At 1:07 PM, Staff A, Administrator, said ADs should be reviewed and addressed at the initial care conference. Staff A stated, Yes. We know there were issues.</p> <p>Reference WAC 388-97-0280 (3)(c)(i)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47518</p> <p>Based on observation, interview, and record review, the facility failed to obtain a physician's order for 2 of 4 sampled residents (3 & 288) reviewed for physical restraints. This failure placed residents at risk for injury, unmet care needs, and a diminished quality of life.</p> <p>Findings included .</p> <p>Record review of the facility's undated policy entitled, Devices/Enablers Policy and Procedure, documented . Nursing Staff will also obtain a physician order for the device/enabler.</p> <p>1) Resident 3 was admitted to the facility on [DATE]. The quarterly Minimum Data Set (MDS) assessment, dated 08/05/2024, documented Resident 3 was moderately cognitively impaired.</p> <p>On 09/09/2024 at 10:50 AM, Resident 3 was observed lying in bed on their left side with quarter length bed rails on left and right sides of the bed.</p> <p>At 3:17 PM, Resident 3 was observed lying in bed on their back with quarter length bed rails on left and right sides of the bed.</p> <p>Review of Resident 3's Electronic Health Record (EHR) did not show a physician's order related to bed rails.</p> <p>On 09/10/2024 at 1:32 PM, Resident 3 was observed lying in bed on their back with quarter length bed rails on left and right sides of the bed.</p> <p>On 09/11/2024 at 8:51 AM, Resident 3 was observed sitting up in bed eating breakfast with quarter length bed rails on left and right sides of the bed.</p> <p>At 10:34 AM, Resident 3 was observed in bed on their back with quarter length bed rails on left and right sides of the bed.</p> <p>At 3:02 PM, Staff C, Resident Care Manager (RCM) and Registered Nurse (RN), said enablers such as positioning/mobility bars or quarter rails require a doctor's order. Staff C said she could not find an order for Resident 3's quarter bed rails and indicated there should have been one.</p> <p>At 3:18 PM, Staff B, Director of Nursing Services (DNS) and RN, said it was his expectation residents had physician orders for use of enablers such as quarter bed rails or mobility bars.</p> <p>50416</p> <p>2) Resident 288 was admitted to the facility on [DATE]. The admission MDS assessment, dated 09/04/2024, documented Resident 288 was alert and oriented.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 09/09/2024 at 10:03 AM, Resident 288 was observed sitting in her wheelchair next to her bed. Resident's 288 bed was observed to have quarter length bed rails to the left and right sides of the bed.</p> <p>Review of Resident 288's EHR did not show a physician's order related to the use of bed rails.</p> <p>On 09/10/24 at 3:10 PM, Resident 288 was observed sitting in her wheelchair next to her bed. Resident's 288 bed was observed to have quarter length bed rails to the left and right sides of her bed.</p> <p>On 09/13/24 at 8:57 AM, Resident 288 was observed lying in bed watching her television. Resident 288's bed had quarter length bed rails to the left and right side of her bed.</p> <p>Reference WAC 388-97-0620 (1)(a)(b)</p>

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50416</p> <p>Based on interview and record review, the facility failed to ensure a copy of the Notice Before Transfer was sent to a representative of the Office of the State Long-Term Care Ombudsman for 1 for 1 sampled resident (26) reviewed for transfer notice requirements. This failure placed residents at risk of loss of added protection from being inappropriately transferred or discharged from the facility.</p> <p>Findings included .</p> <p>Resident 26 was admitted to the facility on [DATE] with diagnoses including congestive heart failure exacerbation and physical deconditioning. The admission Minimum Data Set assessment, dated 07/24/2024, documented Resident 26 was alert and oriented.</p> <p>Record review of resident's electronic health records documented Resident 26 was transferred to and admitted to a local hospital on 08/26/2024.</p> <p>On 09/11/2024 at 2:01 PM, when asked if a Notice of Transfer for Resident 26 was sent to the Office of the State Long-Term Care Ombudsman, Staff A, Administrator, said he would check whether the notice was sent.</p> <p>On 09/13/2024 at 12:28 PM, Staff A stated .I just found out about when to send a copy of the Notice of Transfer . to the Office of the State Long-Term Care Ombudsman. Staff A said he sent out the Notice of Transfer for the months of June, July and August on 09/11/2024.</p> <p>Reference WAC 388-97-0120 (5)(b)(i)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47518</p> <p>Based on observation, interview, and record review, the facility failed to ensure the Minimum Data Set (MDS) assessment was completed accurately to reflect a resident's oral/dental status for 1 of 1 sampled resident (21) reviewed for assessment accuracy. This failure placed residents at risk for unidentified and/or unmet care needs and a diminished quality of life.</p> <p>Findings included .</p> <p>Resident 21 was admitted to the facility on [DATE]. The Admission/Medicare - 5 day Minimum Data Set assessment, dated 07/30/2024, documented Resident 21 was severely cognitively impaired, did not have tooth fragments or broken natural teeth, had no mouth pain, and was able to be examined.</p> <p>Record review of the Dietitian Consulting Services - Nutrition Assessment, dated 07/29/2024, documented, natural teeth in poor shape.</p> <p>Record review of a Nutrition/Dietary progress note, dated 07/30/2024, documented, teeth in poor shape.</p> <p>On 09/09/2024 at 10:19 AM, Resident 21's mouth was observed to have missing upper teeth, and lower teeth had sharp edges and dark tan in color. Resident 21 said he had mouth pain.</p> <p>On 09/10/2024 at 1:17 PM, Resident 21's upper teeth were observed mostly missing on upper gums with pointed short tooth fragments present. Resident 21's lower teeth were observed to be dark tan in color with multiple sharp jagged points. Resident 21 said his tooth pain was on his bottom teeth. Resident 21 said staff had not talked to him about dental concerns or asked about dental pain.</p> <p>On 09/12/2024 at 2:44 PM, after observing Resident 21's teeth, Staff C, Resident Care Manager and Registered Nurse (RN), talked to Resident 21 and stated, It looks like you're missing teeth. Do your teeth hurt? Resident 21 stated, It hurts all the time. Staff C stated, Yes. [Resident 21] does have some missing or broken teeth. Whatever was left on the bottom are broken teeth. [Resident 21] obviously needs dental care.</p> <p>At 3:05 PM, Staff E, MDS Nurse and RN, said she gathered information for the MDS by looking at the resident's medical records, asked staff, and would talk to the resident about pain. When asked about the oral/dental status of the MDS assessment, Staff E stated, If I don't go and see the resident myself ., she would look at the admission assessment, care conference assessment, or skilled care review. When asked about looking at Resident 21 to assess his oral/dental status or gathering information in the medical record, Staff E stated, That's a good question . I don't remember.</p> <p>At 3:26 PM, after observing Resident 21's teeth, Staff B, Director of Nursing Services and RN, said Resident 21 had broken natural teeth. Staff B indicated the MDS oral/dental status was inaccurate and stated, We need to do a correction on this. Staff B indicated there should be a visual assessment completed for the oral/dental status on the MDS.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>At 3:50 PM, Staff E said she had looked where she got the information for the oral/dental status on Resident 21's MDS, and stated, I probably did not look at [Resident 21's teeth] myself.</p> <p>Reference WAC 388-97-1000 (1)(b), (2)(k)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47518</p> <p>Based on observation, interview and record review, the facility failed to ensure a comprehensive care plan was developed for 1 of 4 sampled residents (6) reviewed for comprehensive care plans. This failure placed residents at risk for unmet care needs and a diminished quality of life.</p> <p>Findings included .</p> <p>Record review of the facility's undated policy entitled, Devices/Enablers Policy and Procedure, documented Use of the device/enabler will be appropriately care planned and added to the resident's Kardex.</p> <p>Resident 6 was admitted to the facility on [DATE]. The admission Minimum Data Set assessment, dated 06/12/2024, documented Resident 6 was severely cognitively impaired.</p> <p>On 09/09/2024 at 10:39 AM, Resident 6's bed was observed with the left side against the wall and a mat on the floor the full length of the bed along the right side.</p> <p>At 11:38 AM, Resident 6 was observed sitting up in a wheelchair in her room with the left side of the bed against the wall.</p> <p>Review of Resident 6's Electronic Health Record comprehensive care plan, did not address the left side of bed against the wall and a mat on the floor along the right side of the bed.</p> <p>On 09/10/2024 at 1:11 PM, Resident 6's bed was observed with the left side against the wall and a mat leaning up against a wall away from the bed.</p> <p>On 09/11/2024 at 10:36 AM, Resident 6's was observed lying on the bed on her left side with the left side of the bed against the wall and a mat on the floor the full length of the bed along the right side.</p> <p>At 1:45 PM, Resident 6 was observed sitting up in a wheelchair in her room with the left side of the bed against the wall.</p> <p>At 2:30 PM, when asked how they knew the care needs of a resident, Staff D, Certified Nursing Assistant, stated, We look at the [resident's] care plan.</p> <p>At 3:02 PM, Staff C, Resident Care Manager and Registered Nurse (RN), said residents with their bed placed against the wall and a mat on the floor should have it care planned. Staff C said she could not find a care plan for Resident 6's bed against the wall and mats on the floor. Staff C stated, It should be in the care plan.</p> <p>At 3:18 PM, Staff B, Director of Nursing Services and RN, said it was his expectation care plans were in place for residents with their bed against the wall and mats on the floor.</p> <p>(continued on next page)</p>		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference WAC 388-97-1020 (1), (2)(a)(c)

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37934</p> <p>Based on observation, interview and record review, the facility failed to ensure activities of (ADLs) care was provided for dependent residents including nail care for 1 of 2 sampled residents (5) reviewed for ADLs. This failure placed residents at risk of not receiving the care and assistance needed for which they were unable to perform themselves.</p> <p>Findings included .</p> <p>The facility's policy entitled, Nail Care, dated 01/01/2024, indicated I. Nail care which we considered a part of personal hygiene/grooming and is provided by the certified nursing assistant if the resident is not diabetic, and the nails are not severe or complicated. II. If the resident is diabetic the nail care will be done by the licensed nurse due to being higher risk. III. The resident nails are checked for cleanliness and length as a standard of care in grooming/hygiene for the certified nursing assistant and cleaned as needed and nail care is offered.</p> <p>Resident 5 was admitted on [DATE]. The annual Minimum Data Set assessment, dated 08/14/2024, indicated Resident 5 was severely cognitively impaired and needed substantial/maximal assistance with personal hygiene.</p> <p>The ADLs care plan, initiated 08/09/2024, documented check nail length and trim and clean on bath day and as necessary.</p> <p>The Tub/Shower task, dated 09/10/2024, documented Resident 5's last bath or shower was on 08/31/2024.</p> <p>On 09/09/2024 at 12:06 PM, Resident 5 said he would like to have assistance getting his nails trimmed.</p> <p>On 09/10/2024 at 2:14 PM, Resident 5's fingernails were about a 1/3 inch long. Resident 5 said he mentioned to the bath aid he would like his nails done but was told they were not able to do them. Resident 5 said the nails have not been done for about a month.</p> <p>At 2:50 PM, Staff I, Nursing Assistant (NA), said they checked resident nails when they did baths or showers. Staff I said resident nail care was done by the the NA unless the resident was diabetic, for which they would report to the nurse.</p> <p>At 2:59 PM, Staff B, Director of Nursing Services and Registered Nurse, said shower aid would do finger nail care at the time of the resident's baths but the nurse would do the nail care if the resident was diabetic. After observing Resident 5's fingernails, Staff B said it looked like they had not been trimmed for about two weeks.</p> <p>Reference WAC 388-97-1060 (3)(j)(vii)</p>

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<p>F 0847</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47518</p> <p>Based on interview and record review, the facility failed to explain the arbitration (a procedure used to settle a dispute using an independent person mutually agreed upon by both parties) agreement in a manner of which the resident and/or representative understood for 1 of 3 sampled residents (25) reviewed for arbitration agreement. This failure placed residents at risk of losing legal protections, forfeiture (loss or giving up of something) of the right to a jury or court, lack of understanding of the legal document signed, and a diminished quality of life.</p> <p>Findings included .</p> <p>Review of the facility's Optional Voluntary Arbitration Agreement documented, 5. Right to Rescind this Agreement. You may rescind this Agreement to arbitrate within thirty (30) days after signing it by giving written notice of your withdrawal to the Facility .</p> <p>Resident 25 was admitted to the facility on [DATE] and readmitted on [DATE]. The Admission/Medicare - 5 day Minimum Data Set assessment, dated 08/13/2024, documented Resident 25 was alert and oriented.</p> <p>Review of Resident 25's Nursing Note, dated 08/17/2024, documented, .resident believed she was in a hotel and wanted to speak with the manager about her bill .</p> <p>Review of Resident 25's Nursing Note, dated 08/18/2024, documented, .some confusion prior to sleep.</p> <p>Review of Resident 25's Daily Skilled Nursing Charting progress note, dated 08/28/2024, documented, .res [resident] is alert and oriented [A&O] x2 [when someone knows who they are and where they are, but not what time it is], reoriented to time of day .</p> <p>Review of Resident 25's Daily Skilled Nursing Charting progress note, dated 08/30/2024, documented, .A&O x2, some confusion .</p> <p>Review of Resident 25's Daily Skilled Nursing Charting progress note, dated 09/01/2024, documented, .Res alert with some confusion/forgetfulness .</p> <p>Record review of Resident 25's Optional Voluntary Arbitration Agreement, dated 08/29/2024, showed the arbitration agreement was signed by Resident 25 and Staff J, Admissions Coordinator.</p> <p>On 09/13/2024 at 11:25 AM, when asked if Resident 25 recalled signing a binding arbitration agreement, or if staff reviewed a binding arbitration agreement with her, Resident 25 stated, I was under pain with a broken hip. I can't remember any paperwork. Maybe my sister signed it. When asked if Resident 25 knew what a binding arbitration agreement meant, Resident 25 shook her head no and said she was kinda unsure.</p> <p>(continued on next page)</p>		

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<p>F 0847</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>At 11:41 AM, Staff J said to determine if a resident was capable to sign an arbitration agreement, she would ask them cognitive questions such as, what was the day, month, and the resident's name. Staff J said she would also ask the social services department if a resident could sign their own paperwork. When asked what was explained to residents and/or their representative regarding their right to rescind an arbitration agreement, Staff J said she would tell them if they changed their mind, the facility could change it at any time. Staff J stated, I can't imagine there ever being a time they can't change their mind. After looking at the facility's arbitration agreement, Staff J said she was not aware they had only 30 days to change their mind. When asked if it was explained to a resident and/or their representative they had 30 days to change their mind, Staff J stated, No. I didn't tell them they have only 30 days to change their mind . It bothers me that I didn't know that.</p> <p>At 11:59 AM, Staff A, Administrator, said he did not know for how long after signing an arbitration agreement it could be rescinded, and stated, They have as much time as they like. I don't know.</p> <p>No WAC Reference</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>50416</p> <p>Based on observation, interview and record review, the facility failed to ensure infection prevention practices are being maintained including proper use of personal protective equipment (PPE) and hand hygiene for 2 of 8 sampled residents (26 & 30) reviewed for infection prevention and control. These failures placed residents at risk of communicable infections and a decreased quality of life.</p> <p>Findings included .</p> <p>Record review of the facility's Employee Training on Infection Prevention and Control policy, dated 11/01/2018, documented staff trainings and education regarding infection prevention and control included hand hygiene and use of PPE.</p> <p>1) On 09/10/2024 at 1:58 PM, Staff F, Certified Nurse Assistant (CNA), was observed providing care for Resident 26. Staff F took off her gloves, opened Resident 26's door and proceed to retrieve gloves from the isolation cart located outside the room. Staff F then returned into the room, put on the new pair of gloves and continued to provide resident care. When asked about the process for doffing PPE between care, Staff F said she should have washed her hands in between changing gloves.</p> <p>2) On 09/10/2024 at 3:37 PM, Resident 30's room was observed with an enhanced barrier precautions sign on the door and an isolation cart outside the room.</p> <p>At 3:38 PM, Staff G, CNA, and Staff H, CNA, went into Resident 30's room to provide incontinence care for Resident 30. Staff G and Staff H did not put on isolation gowns.</p> <p>At 3:58 PM, Staff G was observed taking trash out of the Resident 30's room with the same gloves used to provide incontinence care for Resident 30. Staff G then went to the dirty utility room door, entered the code on the door using the contaminated gloves, opened the door and threw the trash away. Staff G then took her gloves off, returned to Resident 30's room and sanitized her hands. While in Resident 30's room, Staff G put on gloves and collected dirty linen, bagged the linen in a plastic bag, left the room with the gloves on both her hands. Staff G then went to the dirty utility room door, entered the code on the door using the contaminated gloves and discarded the dirty linen.</p> <p>At 4:03 PM, when asked if Resident 30 was on isolation precautions, Staff G stated, Right now I am not sure. When asked how she would know what kind of isolation precautions a resident was on, Staff G stated, We are informed by the charge nurse or the sign outside of the door. When asked about the use of contaminated gloves outside of Resident 30's room, Staff G stated Yes, I had gloves on.</p> <p>On 09/11/2024 at 11:46 AM, Staff B, Director of Nursing Services and Registered Nurse, said infection control trainings were provided on hire date and during staff meetings. Staff B said it was the expectation staff would use the isolation precaution signs outside of resident's doors to identify the appropriate PPE to use during care. Staff B said it was the expectation staff removed contaminated gloves and perform hand hygiene before leaving the resident's room.</p> <p>Reference WAC 388-97-1320 (1)(c)(2)(b)</p>