STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505306	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Port Townsend	751 Kearney Street Port Townsend, WA 98368

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on observation, interview, and record review the facility failed to ensure that potential restraints were appropriately assessed for safety, care planned, and/or documented on for 3 of 3 residents (Residents 14, 16, & 29) reviewed for physical restraints. This failure placed residents at risk for unidentified risks and care needs, of the potential for restraint, and for a diminished quality of life. Findings included . 1) Resident 14 was admitted to the facility on [DATE]. Review of the Quarterly Minimum Data Set Assessment (MDS), dated [DATE], showed Resident 14 was cognitively intact, was not in any therapies, had lower extremity impairment, and was dependent on staff for toileting/dressing. On 04/07/2025 at 10:42 AM, Resident 14 was observed with their bed against the wall. Review of the Electronic Health Record (EHR) showed Resident 14 had not had a physical restraint evaluation done for the bed against the wall. Review of Resident 14's care plans showed there was not a care plan for the bed against the wall. On 04/10/2025 at 10:15 AM, Staff F, Resident Care Manager (RCM), said for the bed against the wall there should be consent, an assessment done, and a care plan. Staff F was unable to locate an assessment for the bed against the wall or a care plan for Resident 14, and said there should be. On 04/11/2025 at 9:37 AM, Staff J, Rehabilitation Director, and Staff B, Director of Nursing (DNS), were jointly interviewed. When asked if Resident 14 had an order for their bed against the wall, Staff J said there was an order now and Staff B said it should have been done before. When asked if it met expectations that Resident 14 did not have an assessment done to show the bed against the wall was not acting as a restraint, Staff B said it did not. 2) Resident 16 was admitted to the facility on [DATE], and had diagnoses of right femur facture and difficulty in walking. The Modification of Significant Change MDS, dated [DATE], showed Resident 16 was moderately impaired cognitively. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/07/2025 at 2:06 PM, Resident 16 was observed to have their bed against the wall and one mobility bar (side rails on the upper part of the bed to assist with moving in the bed) attached to the bed. Review of the EHR showed Resident 16 did not have a physical restraint evaluation done for having a mobility bar, or for having their bed against the wall. On 04/10/2025 at 10:15 AM, Staff F, RCM, when asked if there was an assessment for Resident 16's bed against the wall to show it was not acting as a restraint, said it should have been done, and they would fix it. When asked about if there was an assessment done for the mobility bar to show it was not acting as a restraint, said they would need to do a new assessment on Resident 16 for the bed rail and there should have been one already. On 04/11/2025 at 9:37 AM, Staff J, Rehabilitation Director, and Staff B, DNS, were jointly interviewed. Both staff agreed that an order should have been placed for Resident 16 to have their bed against the wall. When asked if it met expectations that there was not previously an assessment done for the bed against the wall, said no it did not meet expectations. 3) Resident 29 admitted to the facility on [DATE] with diagnoses that included dementia, depression, anxiety, and muscle weakness. The Significant Change MDS, dated [DATE], showed Resident 29 was confused but could make their needs known. Observation on 04/07/2025 at 12:44 PM, showed Resident 29's bed was against the wall on the left side. Review of the EHR showed Resident 29 had not had an assessment for restraints completed for the bed against the wall. Review of Resident 29's care plan showed there was not a care plan in place for the bed against the wall. During an interview on 04/10/2025 at 10:34 AM, Staff U, Licensed Practical Nurse, stated if a resident had their bed against the wall, a consent would have been obtained, and a restraint assessment would have been done. During an interview on 04/10/2025 at 11:30 AM, Staff F, RCM, stated the facility did not have a restraint assessment for the bed against the wall, therefore Resident 29 did not have a restraint assessment completed. On 04/11/2025 at 9:37 AM, Staff J, Rehabilitation Director, and Staff B, DNS, were jointly interviewed. When asked if it met expectations that there was not an assessment done for Resident 29's bed against the wall, they said no it did not meet expectations. Reference WAC 388-97-0620(1) .

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2) Resident 1 was admitted to the facility on [DATE], with a diagnosis of major depressive disorder. Review of Resident 1's Level 1 PASRR evaluation, dated 04/04/2023, showed the evaluator had selected yes for a serious mental illness indicator, with mood disorders (depressive or bipolar) selected. During an interview on 04/10/2025 at 1:19 PM, Staff H, SSD, after reviewing guidance from the PASRR dear provider letter, said Resident 1 should have had a referral placed for a Level 2 PASRR evaluation. Reference WAC 388-97-1915 (4) Based on interview and record review, the facility failed to obtain an updated preadmission screening and resident review (PASRR, a mental health screening tool) when a diagnosis of significant mental illness was identified for 2 of 5 residents (Resident 4 & 1) reviewed for PASRR. This failure placed the residents at risk for unmet care needs and a decreased quality of life. Findings included . 1) Resident 4 admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease, anxiety, depression, and bipolar disorder (a mental disorder characterized by periods of depression and periods of abnormally elevated mood). The Quarterly Minimum Data Set (MDS, an assessment tool), dated 02/21/2025, showed Resident 4 was confused with poor memory recall. Review of Resident 4's Level 1 PASRR, dated 03/07/2025, showed Serious Mental Illness indicators of mood disorders and anxiety disorders had been selected. During an interview on 04/10/2025 at 1:19 PM, when reviewing guidance from the PASRR dear provider letter (a letter that provides facilities with updated regulation changes) with an amended date of 08/23/2024, Staff H, Social Services Director (SSD) said Resident 4 should have been referred for a Level 2 PASRR.

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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 ensure the comprehensive care plan included resident specific interventions for 5 of 12 sampled residents (Residents 42, 14, 16, 26 & 29) reviewed for care plans. This failure to establish care plans that were individualized, accurately reflected assessed care needs and provided direction to staff, placed residents at risk to receive inappropriate and inadequate care to meet their individual needs. Findings included . 1) Resident 42 was admitted to the facility on [DATE]. According to the Modification of Admission/Medicare 5-day Minimum Data Set (MDS, and assessment tool), dated 03/08/2025, Resident 42 required supervision or touching assistance for oral hygiene. Resident 42's diagnoses included Malignant Neoplasm of Rectum (cancer of the rectum). Review of Resident 42's physician orders showed three medications prescribed to treat chronic diarrhea. Review of Resident 42's care plan showed Resident 42 had occasional bowel incontinence related to rectal cancer, was incontinent, and wore a brief. There was nothing on the care plan regarding chronic diarrhea. On 04/09/2025 at 2:42 PM, Staff T, Certified Nursing Assistant (CNA), when asked to describe Resident 42's bowel movements, said they were always loose and they had never seen formed stools. On 04/09/2025 at 2:44 PM, Staff F, Resident Care Manager (RCM), said staff would know if a resident had chronic diarrhea if there was a diagnosis or from looking at the prescribed medications. When asked if Resident 42's chronic diarrhea should be on the care plan, Staff F said if related to rectal cancer then yes, I think so. Staff F said Resident 42 sometimes refused their medication to treat diarrhea and that refusals should also have been care planned. Review of the Modification of admission MDS, showed Resident 42 required supervision or touching assistance for oral hygiene. Review of Resident 42's care plan showed there was no plan for their oral hygiene. On 04/10/2025 at 11:00 AM, Staff F, RCM, said Resident 42 would need someone to set up their oral hygiene supplies for them since they couldn't get out of bed and were visually impaired. When asked if oral hygiene was on Resident 42's care plan, Staff F said she did not see that dental care was on their care plan and it should have been there. 2) Resident 14 was admitted to the facility on [DATE]. Review of the Quarterly MDS, dated [DATE], showed Resident 14 was cognitively intact. On 04/07/2025 at 10:42 AM, Resident 14 was observed with their bed against the wall. Review of Resident 14's care plans showed there was not a care plan for the bed against the wall. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/10/2025 at 10:15 AM, Staff F, RCM, when asked if the bed against the wall should be care planned, said yes. Staff F was unable to locate a care plan for Resident 14's bed against the wall and said there should be one. On 04/11/2025 at 9:37 AM, Staff J, Rehabilitation Director, and Staff B, Director of Nursing (DNS), were jointly interviewed. When asked if it met expectations the bed was against the wall and was not on the care plan, Staff J said it was now on the care plan. 3) Resident 16 was admitted to the facility on [DATE] and had a diagnosis of chronic heart failure. The Modification of Significant Change MDS, dated [DATE], showed Resident 16 was moderately impaired cognitively, and was taking a diuretic (increases the need to urinate to remove excess fluid and can decrease blood pressure). Review of Resident 16's medications showed they were receiving torsemide (a diuretic). Review of Resident 16's Treatement Administration Record for April 2025 showed they had edema (excess fluid causing swelling) present on assessments. On 04/10/2025 at 10:15 AM, Staff F, RCM, when asked if Resident 16's diuretic usage should be care planned, said it was not on the care plan and should have been due to the potential for fluid loss and dehydration prevention. When asked about Resident 16's edema and if goals/interventions should have been on the care plan, said they did not see anything and yes, the edema should have been care planned with goals and interventions. 4) Resident 26 was admitted to the facility on [DATE]. Review of the admission MDS, dated [DATE], showed Resident 26 was cognitively intact. Review of the admission Collection Tool, dated 03/01/2025, showed it was identified that Resident 26 was missing teeth. On 04/07/2025 at 3:01 PM, Resident 26 reported that they were missing some teeth and would like to go to the dentist if they could. On 04/10/2025 at 10:15 AM, Staff F, RCM, reviewed the admission Collection Tool and said yes Resident 26 was missing natural teeth. Staff F reviewed Resident 26's care plans and said the missing teeth were not on the care plan and should have been. 5) Resident 29 admitted to the facility on [DATE] with diagnoses that included dementia, depression, anxiety, and muscle weakness. The Significant Change MDS, dated [DATE], showed Resident 29 was confused but could make their needs known. Observation on 04/07/2025 at 12:44 PM, showed Resident 29's bed was against the wall on the left side. Review of the provider orders, dated 02/26/2025, showed Resident 29 had an order in place for bed against the wall to increase environmental space. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan on 04/09/2025 showed Resident 29 did not have a care plan in place for the bed against the wall. During an interview on 04/10/2025 at 11:30 AM, Staff F, RCM, said if a resident has a bed against the wall, it should be care planned. On 04/11/2025 at 9:37 AM, Staff J, Rehabilitation Director, and Staff B, DNS, were jointly interviewed. When asked if it met expectations the bed being against the wall was not on the care plan, Staff J said it now was on the care plan. Reference F604. Reference F677. Reference WAC 388-97- 1020(1), (2)(a)(b) .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on interview and record review, the facility failed to ensure services provided met professional standards of practice related to performing daily weights and accurate documentation of side effects for 1 of 5 residents (Resident 23) reviewed for unnecessary medications, failed to follow hospice (end of life care) recommendations for 1 of 1 resident (Resident 28) reviewed for hospice, and failed to monitor after a change in status for 1 of 2 residents (Resident 29) reviewed for hospitalization. These failures placed residents at risk for unmet care needs,the provider not being aware of resident conditions, and potential negative outcomes. Findings included . <Daily weights> Resident 23 admitted to the facility on [DATE]. The admission Medicare 5-day Minimum Data Set (MDS, and assessment tool), dated 04/01/2025, documented Resident 23 was cognitively intact. Resident 23 had diagnoses that included Unspecified Systolic (Congestive) Heart Failure (CHF, a condition where the heart can't pump blood effectively, leading to fluid buildup in the lungs and other parts of the body) and adjustment disorder with depressed mood. Review of Resident 23's physician orders showed an order for CHF Protocol - Weight every day shift before breakfast. Report three pounds (lb.) weight gain in a day or five pound weight gain in a week to the medical doctor. Review of Resident 23's weight record from 03/27/2025 through 04/09/2025 showed the following two weights had been taken. 03/27/2025 252.0 lbs. 04/03/2025 244.2 lbs No weight had been recorded on the following dates: 03/28/2025, 03/29/2025, 03/30/2025, 03/31/2025, 04/01/2025, 04/02/2025, 04/04/2025, 04/05/2025, 04/06/2025, 04/07/2025, 04/08/2025, and 04/09/2025. On 04/09/2025 at 9:31 AM, Staff F, Resident Care Manager (RCM), acknowledged the physician order for daily weights for Resident 23. Regarding the days with missed weights Staff F said some of the dates were missing because Resident 23 could not be weighed due to the location of their surgical incision. Staff F said when a weight could not be obtained staff should have let the provider know. When asked if daily weights should have been done when Resident 23 was able to be weighed, Staff F said yes, they should have been done and for the missing weights she did not see documentation that the provider had been notified. <Failure to complete documentation> (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 23's orders showed an order for Trazadone (antidepressant), give 100 milligrams at bedtime for situational depression. Review of Resident 23's April 2025 Treatment Administration Record (TAR) showed the following order: Anti-Depressant Medication: Trazodone. Side effects: Common - Sedation, Drowsiness, Dry Mouth, Blurred Vision, Urinary Retention, Tachycardia (elevated heart rate), Muscle Tremor, Agitation, Headache, Skin Rash, Photosensitivity (sensitivity to light), Excess Weight Gain. Special Attention for: Heart Disease, glaucoma (eye disorder), Chronic Constipation, Seizure Disorder, Edema (fluid retention). Monitor every shift Document: (+) if side effects present and write a progress note (-) side effects not present. Review of the documentation for side effects showed positive (+) side effects were documented by staff on the following dates: 04/06/2025 (day and night shift), 04/07/2025 (day and night shift), 04/08/2025 (day and night shift) and 04/09/2025 (day shift). On 04/09/2025 at 9:31 AM, Staff F, RCM, reviewed the documentation in the TAR and acknowledged staff had documented that Resident 23 was positive for side effects on the above dates. Staff F said staff probably checked positive for side effects in error, and if a positive result was documented staff should have documented in a progress note the positive symptoms. Staff F was unable to locate progress notes for the dates in question and said progress notes should have been written either way. <Hospice recommendations> Resident 28 admitted to the facility on [DATE] with diagnoses that included dementia and neoplasm of the oral cavity (mouth cancer). The Significant Change MDS, dated [DATE], showed Resident 29 was able to make their needs known. Observation on 04/08/2025 at 10:09 AM, showed Resident 28 had visible lesions on their bottom lip into the gum line. Review of the Electronic Health Record (EHR) showed Resident 28 was on hospice care with comfort measures. Review of the Hospice admission summary, dated [DATE], showed hospice had made a recommendation for A&D ointment (a moisturizer and skin protectant) to be applied to the cancer lesions to prevent drying and cracking to the wounds. Review of the provider orders showed there was no order for the recommended ointment to the cancer lesions and no orders for wound care to the cancer lesions. Review of the progress notes on 04/08/2025, showed no notes regarding the hospice recommendation. During an interview on 04/10/2025 at 9:36 AM, Staff Q, Certified Nursing Assistant, said the staff provided oral care with green sponges and used a mouthwash to cleanse Resident 28's mouth. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/10/2025 at 10:37 AM, Staff U, Licensed Practical Nurse (LPN) said care of Resident 28's cancer lesions was pain management and oral care. Staff U said there was no further orders for wound care. In an interview on 4/10/2025 at 11:30 AM, Staff F, RCM, said the care of the cancer lesion wounds was pain management and oral care. When the hospice admission assessment was showed to Staff F, they stated the recommended treatment had not been transcribed to the provider orders and the provider should have been notified of the recommendations. During and interview on 04/11/2025 at 10:35 AM, Staff B, DNS, said the recommendations should have been reviewed, reported to the provider, and transcribed if approved by the provider. Staff B said that did not happen and does not meet their expectations. <Failure to monitor> Resident 29 admitted to the facility on [DATE] with diagnoses that included dementia, depression, anxiety, and muscle weakness. The Significant Change MDS, dated [DATE], showed Resident 29 was confused but could make their needs known. Review of the EHR showed Resident 29 was transferred to the hospital on [DATE] for nausea and vomiting. Review of the hospital records showed Resident 29 was diagnosed with a gastrointestinal bleed and pneumonia. Resident 29 readmitted to the facility on [DATE]. Review of the progress notes showed Resident 29 was not started on alert charting upon readmission to the facility. During and interview on 04/10/2025 at 10:31 AM, Staff U, LPN, said if there was a change in status, a resident would be placed on alert charting, and charted on every shift. During an interview on 04/10/2025 at 11:30 AM, Staff F, RCM, said alert charting should be completed daily on any change of condition. Staff F said Resident 29 should have been placed on alert when they readmitted to the facility. During an interview on 04/11/2025 at 10:35 AM, Staff B, DNS, said alert charting should be done every shift. Staff B said Resident 29 had not being placed on alert upon readmission did not meet their expectations. Reference WAC 388-97-1620(2)(b)(i)(ii),(6)(b)(i) .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on observation, interview and record review, the facility failed to ensure dependent residents were provided with oral care for 2 of 3 residents (Resident 42 & 14) reviewed for dental care related to activities of daily living. This failure placed residents at risk for poor oral hygiene, worsening dental condition, and a diminished quality of life. Findings included . A facility provided policy titled, Activities of Daily Living (ADLs), reviewed 09/10/2024, documented, the resident would receive assistance as needed to complete ADLs. 1) Resident 42 was admitted to the facility on [DATE]. The Modification of Admission/Medicare 5-day Minimum Data Set (MDS, and assessment tool), dated 03/08/2025, documented Resident 42 required supervision or touching assistance for oral hygiene, and required partial/moderate assistance to transfer from chair/bed-to-chair. On 04/07/2025 at 2:21 PM, Resident 42 said one great deficiency the facility had was dental hygiene. Resident 42 said they had not brushed their teeth in two months, and said staff had only offered one time to help them. Resident 42 said their brother had brought in a toiletry bag with a toothbrush, and that they could brush their own teeth if staff brought their supplies and stuff so they could rinse and spit. Resident 42's teeth were observed to be yellow in color with a whitish substance near their upper and lower gums. On 04/08/2025 at 11:11 AM, Resident 42 said he still had not had dental care offered or provided since the previous day. Resident 42's teeth were observed to be yellow in color with a whitish substance near their upper and lower gums. On 04/10/2025 at 10:45 AM, Staff S, Certified Nursing Assistant (CNA), said she provided oral care to the residents as part of her day. When asked how often oral care was provided to residents, Staff S said every meal. When asked about toothbrushing, Staff S said it was dependent on the care plan for that resident and if the resident had natural teeth staff would brush them if they could not do it themselves. When asked where the toothbrushing that was provided would be documented, Staff S said there was a 'Personal Hygiene' area in the electronic health record (EHR) where they documented it. When asked if she had provided oral care to Resident 42, Staff S said she was not normally on Resident 42's hallway, she was just helping that day and said, I think they are doing it. Review of Resident 42's Care Plan, did not show a focus or intervention regarding oral/dental care. Review of the EHR showed no specific area/direction for documenting/providing oral care. Review of Resident 42's orders showed nothing regarding oral/dental care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/10/2025 at 11:00 AM, when asked about Resident 42's oral care and assistance, Staff F, Resident Care Manager (RCM), said Resident 42 would not allow anyone near their mouth and wanted to remain independent. When asked if dental/oral care was on their care plan, Staff F said no, it was not on the care plan but should be. Staff F said Resident 42 would need someone to set up oral care supplies for them since they could not get out of bed and was visually impaired. Staff F said oral care should have been offered and done after every meal. When asked how the CNAs would know to provide oral care and document they had provided oral care for Resident 42, Staff F said it should be on their KARDEX (an area in the EHR with tasks for CNAs to complete and document). When asked if Resident 42 had an area for oral hygiene/care on the Kardex to indicate to staff to provide oral care, Staff F looked in the EHR and said no, and that it should have been there. At 11:06 AM, Staff F, RCM, entered Resident 42's room to observe his oral cavity. Upon leaving the room, Staff F said she was able to observe plaque and food build up along Resident 42's gums. When asked if this was acceptable, Staff F said no, and that she could even smell Resident 42's mouth. 2) Resident 14 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], said Resident 14 needed set up or clean- up assistance for oral hygiene (oral care). Resident 14 was dependent on staff to get out of bed. Review of Resident 14's care plans showed that dental care was identified as a concern, with a note that the resident would comply with mouth care at least daily through the review date, and for staff to provide set up assistance after meals. On 04/07/2025 at 11:52 AM, Resident 14 said they were independent with oral care but did require set up assistance, and they did not currently have supplies to brush their teeth. On 04/10/2025 at 9:34 AM, Staff G, CNA, said they had been working with Resident 14 since they were admitted to the facility, Resident 14 did not independently do much oral care, and if offered that Resident 14 probably would perform oral care. Staff G said they had not recently seen Resident 14 perform oral care, did not think oral care was happening daily, and when asked what time Resident 14 was supposed to have oral care done, said probably in the morning. When asked what kind of assistance Resident 14 would need, Staff G said said set up assistance. Staff G said there was no place for staff to document oral care was done. When asked where the supplies were in the room, Staff G was unable to locate supplies, then offered Resident 14 supplies and said they would go get them. At 10:15 AM, Staff F, RCM, said it did not meet expectations that Resident 14 did not have oral care supplies in their room. Staff F said their expectation was for oral care to occur after every meal. At 1:37 PM, when told of Staff G being unable to readily locate Resident 14's oral care supplies in the room, Staff B, Director of Nursing Services, said it did not meet expectations. Reference WAC 388-97-1060 (2)(c) .

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Life Care Center of Port Townsend	751 Kearney Street Port Townsend, WA 98368

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 provide non-pharmacological interventions (health interventions/approaches used instead of medication), to implement and/or follow parameters for medications, and/or to reassess necessity of medication when vitals were abnormal for 3 of 6 sampled residents (Residents 19, 23 & 16) when reviewed for unnecessary medications and/or pain management. This failure placed the residents at risk for receiving unnecessary medications, avoidable medication side effects, and a diminished quality of life. Findings included . 1) Resident 19 was admitted to the facility on [DATE]. The Annual Minimum Dated Set (MDS, an assessment tool) , dated 02/07/2025, documented Resident 19 was cognitively intact. Resident 19 received an opioid medication for pain. A physician's order, dated 02/02/2023, documented Resident 19 was to be given the opioid medication when the pain level was above 3. Non-pharmacological interventions were to be offered and completed prior to medication administration. The non-pharmacological interventions included repositioning, use of pillows, diversional activities & rest. Resident 19's March and April 2025 Medication Administration Record (MAR) and Treatment Administration Record (TAR) showed no documentation that non-pharmacological interventions were offered or completed. On 04/10/2025 at 9:57 AM, Staff F, Resident Care Manager (RCM), said non-pharmacological interventions should be documented on the TAR, they have a system that automatically codes for pain, staff should be entering the effectiveness of the pain medication and other interventions used. When asked to provide Resident 19's non-pharmacological interventions documentation, Staff F said the non-pharmacological interventions were not entered on the TAR and they should have been. At 11:52 AM, Staff B, Director of Nursing Services (DNS), said staff should be asking the resident if they have pain and documenting the pain score. Staff F said staff should have been asking, providing and documenting all non-pharmacological interventions used. When asked to provide Resident 19's non-pharmacological interventions documentation, Staff B said the non-pharmacological interventions were not entered on the TAR and they should have been. 2) Resident 23 admitted to the facility 03/27/2025. The admission Medicare 5-day MDS dated [DATE], documented Resident 23 was cognitively intact. Resident 23 had diagnoses that included Unspecified Systolic (Congestive) Heart Failure (CHF, a condition where the heart can't pump blood effectively, leading to fluid buildup in the lungs and other parts of the body). Resident 23 had an order, dated 03/31/2025, for Oxycodone (pain medication) 5 milligram (mg) tablet, give 0.5 tablet (half of a tablet, or 2.5 mg) by mouth every 12 hours as needed for pain 4-6/10 (Pain scale 1-10, 1 being very little pain, and 10 being severe pain). Nonpharmacological interventions were to be attempted prior to administering the pain medication. Nonpharmacological interventions to have been attempted included repositioning, distracting activity, ice and offer a snack. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 23 had a second order, dated 03/31/2025, for Oxycodone 5 mg tablet, give 1 tablet by mouth every 12 hours a needed for pain 7-10/10. Nonpharmacological interventions were to be attempted prior to administering the pain medication. Nonpharmacological interventions to have been attempted included repositioning, distracting activity, ice and offer a snack. Review of the April 2025 MAR showed Resident 23 was administered Oxycodone 5 mg tablet when pain was below 7/10 on: 04/01/2025- pain level documented at a 3/10, 1 tablet given (5 mg) 04/03/2025- pain level documented at a 3/10, 1 tablet given (5 mg) 04/05/2025- pain level documented at a 5/10, 1 tablet given (5 mg) 04/07/2025- pain level documented at a 3/10, 1 tablet given (5 mg) Review of the April 2025 MAR and TAR showed no documentation that nonpharmacological interventions had been attempted prior to the Oxycodone administration as ordered for the following administration dates: 04/01/2025, 04/02/2025, 04/03/2025, 04/05/2025, 04/06/2025 & 04/07/2025. On 04/09/2025 at 9:31 AM, Staff F, RCM, acknowledged that 5 mg tablets were given on the above dates when pain levels were under 7-10/10. Staff F said this did not meet her expectations, and said 2.5 mg (half of a tablet) should have been given. Regarding the nonpharmacological interventions, Staff F said once a resident says they are in pain, staff would find out where the pain was and then apply the nonpharmacological interventions, if the interventions were unsuccessful then staff would give the pain medication. When asked to show documentation that nonpharmacological interventions had been attempted prior to the above Oxycodone administration dates, Staff F said that the order needed to be updated as staff did not have the option to document the interventions. When asked if the lack of documentation met her expectations, Staff F said, no. Resident 23 was receiving three different anti-hypertensive medications (medications that can lower blood pressure) and two diuretics (medications that can remove excess fluid and lower blood pressure). Record review of Resident 23's blood pressure documentation from 04/01/2025 through 04/09/2025 showed they had the following low blood pressure readings on: 04/02/2025- 99/55 04/04/2025- 99/54 04/06/2025- 96/50 (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/09/2025 at 9:31 AM, Staff F, RCM, regarding Resident 23 being on three anti-hypertensive medications and two diuretics that could all lower blood pressures, Staff F said, there should have been parameters (blood pressure guidelines for when to hold the anti-hypertensive medications) on all anti-hypertensive medications. Staff F acknowledged the low blood pressure readings for Resident 23 and when asked if there were parameters on the three anti-hypertensive medications Resident 23 was taking, Staff F acknowledged that there was not and said there should have been. 3) Resident 16 was admitted to the facility on [DATE]. The Modification of Significant Change MDS, dated [DATE], showed Resident 16 was moderately impaired cognitively. Review of the MAR showed Resident 16 had an order for hydromorphone (an opioid pain medication) for every 12 hours as needed for severe pain of 7-10/10, with an order to attempt non-medication (non-pharmacological interventions) prior to administering as needed pain medications. Non-pharmacological interventions were listed as repositioning, distracting activity, ice, and offering a snack. Hydromorphone was administered without documentation of non-pharmacological interventions. Hydromorphone was adminstered with a pain score less than 7 on the following days: 04/03/2025 for a pain score of 5 04/04/2025 for a pain score of 6 04/05/2025 for a pain score of 5 04/08/2025 for a pain score of 4 04/09/2025 for a pain score of 6 Further review of the MAR showed Resident 16 was receiving a diuretic (increases the need to urinate to remove excess fluid and can decrease blood pressure) named torsemide. When comparing the MAR to the blood pressure (BP) vital signs, Resident 16 was found to have received doses of torsemide, despite having low blood pressure readings. The MAR and BP vitals showed the 4:30 PM dose of torsemide was given without provider notification or a recheck of blood pressure, on the following dates: 02/11/2025 at 11:31 AM, Resident 16's BP was 85/48 03/03/2025 at 11:22 AM, Resident 16's BP was 98/50 03/12/2025 at 12:25 PM, Resident 16's BP was 96/50 On 04/10/2025 at 10:15 AM, Staff F, RCM, said there was a protocol for if the systolic BP (number on top) was less than 100, or HR was less than 55. For Resident 16, Staff F said staff should have informed the provider when the BP was that low. In regards to the hydromorphone being given for pain scores of 4-6, Staff F said that did not meet expectations. When asked their expectations for non-pharmacological interventions, Staff F said they should have documented on that they were done before every opioid administration. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/11/2025 at 12:20 PM, Staff B, DNS, said they expected non-pharmacological interventions to be documented. Staff B, when asked if it met expectations Resident 16 received hydromorphone for pain scale values outside of parameters, said no. When asked about the low BPs and Resident 16 receiving torsemide doses, said their expectation for staff was to have rechecked the BP and reassessed the situation, and to have called the provider if the BP remained low to see what they should do about medications that could impact the BP. Reference WAC 388-97 -1060 (3)(k)(i) .

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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. . Based on observation, interview, and record review, the facility failed to ensure proper storage and labeling of medications in 1 of 2 medication carts (B Hall medication cart) and 1 of 1 medication rooms when reviewed for medication storage. This failure placed residents at risk for receiving expired medications, ineffective treatment, and a diminished quality of life. Findings included . Observation of the medication cart on B hall on 04/09/2025 at 11:05 AM, with Staff O, Registered Nurse (RN), showed an open insulin pen with no date on it. During an interview on 04/09/2025 at 11:05 AM, Staff O, RN, said they had just opened the insulin pen that morning and forgot to date it. During an interview on 04/10/2025 at 8:35 AM, Staff F, Resident Care Manager (RCM), said all insulin should be dated as soon as it is opened. Observation of the medication room on 04/10/2025 at 8:33 AM, with Staff F, RCM, showed the temperature log for March 2025 was missing 11 of 62 opportunities. Review of the refrigerator showed storage of medication and emergency medication supply. During an interview on 04/10/2025 at 8:33 AM, Staff F said the refrigerator temperature should be monitored twice a day by nursing staff and documented on the log. Observation of the B Hall medication cart on 04/10/2025 at 10:16 AM, showed a cup with food items in it, partially covered with a paper towel, with crumbs on the top surface of the medication cart and three nurses close by the medication cart with no intervention noted. During an interview on 04/11/2025 at 10:16 AM, Staff B, Director of Nursing Services, said the refrigerator temperatures in the medication room should have been documented at assigned times during the day in the morning and evening. Staff B said missing temperatures did not meet expectation, and the insulin pen should have been dated as soon as it was opened. Staff B said food should not have been left on top of the medication cart and this did not meet their expectations. Reference WAC 388-97-1300 (2) .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. . Based on observation, interview and record review the facility failed to ensure dishwasher temperatures were maintained within required ranges for 1 of 1 dishwasher and failed to ensure appropriate personal protective equipment (PPE) was worn for 1 of 4 (Staff I) kitchen staff observed. These failures placed residents at risk of food-borne illness, unsanitary conditions, and a diminished quality of life. Findings included . A facility provided policy titled, Associate Conduct and Dress Code, with a revised date of 04/30/2024, documented dietary staff must wear hair restraints (e.g. hairnet, hat, and/or beard restraint) to prevent hair from contacting food. <Failure to wear PPE> On 04/07/2025 at 10:36 AM and at 12:09 PM, Staff I, Dietary Manager, was observed in the kitchen without a hair restraint on. On 04/09/2025 at 8:57 AM, Staff I was observed in the kitchen without a hair restraint on. At 1:23 PM, Staff I said the expectation was for dietary staff to have their hair covered in the kitchen. When asked about the observations without a hair restraint in the kitchen, Staff I said it should have been covered. <Failure to maintain dishwasher temperatures> Review of the dishwasher temperature logs showed the following out of perimeters temperatures: March 2025 under 150 degrees Fahrenheit Records-Breakfast Wash cycle: 1st, 3rd, 4th, 8th, 9th, 10th, 18th, 20th, 23rd, 26th, 27th, 29th, 30th, 31st. March 2025 under 180 degrees Fahrenheit Records-Breakfast Rinse cycle: 1st, 2nd, 9th, 10th, 14th, 18th, 19th, 23rd, 27th, 28th, 30th, 31st. March 2025 under 150 degrees Fahrenheit Records-Lunch Wash cycle: 1st, 7th, 8th, 9th, 18th, 23rd, 26th, 27th, 28th, 29th, 30th, 31st. March 2025 under 180 degrees Fahrenheit Records-Lunch Rinse cycle: 1st, 7th, 8th, 14th, 20th, 22nd, 23rd, 27th, 29th, 31st. March 2025 under 150 degrees Fahrenheit Records-Dinner Wash cycle: 1st, 2nd, 4th, 5th, 6th, 7th, 8th, 9th, 11th, 12th, 13th, 14th, 18th, 20th, 23rd, 24th, 25th, 26th, 27th, 28th, 29th, 31st. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	March 2025 under 180 degrees Fahrenheit Records-Dinner Rinse cycle: 1st, 4th, 5th, 6th, 7th, 8th, 11th, 12th, 14th, 18th, 21st, 26th, 27th. February 2025 under 150 degrees Fahrenheit Records-Breakfast Wash cycle: 1st, 2nd, 3rd, 4th, 7th, 18th, 9th, 10th, 11th, 13th, 14th, 15th, 16th, 17th, 21st, 22nd, 23rd, 28th. February 2025 under 180 degrees Fahrenheit Records-Breakfast Rinse cycle: 1st, 3rd, 4th, 5th, 6th, 8th, 9th, 10th, 11th, 13th, 14th, 15th, 16th, 17th, 18th, 19th, 22nd, 23rd, 24th, 26th, 18th. February 2025 under 150 degrees Fahrenheit Records-Lunch Wash cycle: 1st, 2nd, 3rd, 4th, 6th, 7th, 8th, 10th, 13th, 14th, 15th, 16th, 17th, 18th, 19th, 21st, 22nd, 23rd, 24th, 25th, 28th. February 2025 under 180 degrees Fahrenheit Records-Lunch Rinse cycle: 1st, 2nd, 3rd, 6th, 7th, 9th, 10th, 11th, 13th, 14th, 15th, 16th, 17th, 18th, 22nd, 23rd, 24th 26th, 28th. February 2025 under 150 degrees Fahrenheit Records-Dinner Wash cycle: 1st, 2nd, 3rd, 4th, 5th, 6th, 7th, 8th, 9th, 10th, 11th, 12th, 13th, 14th, 16th, 17th, 18th, 19th, 20th, 21st, 22nd, 23rd, 24th, 25th, 26th, 27th, 28th. February 2025 under 180 degrees Fahrenheit Records-Dinner Rinse cycle: 1st, 2nd, 3rd, 4th, 5th, 6th, 8th, 12th, 13th, 14th, 18th, 19th, 25th, 26th, 27th. January 2025 under 150 degrees Fahrenheit Records-Breakfast Wash cycle: 5th, 6th, 7th, 8th, 9th, 10th, 11th, 13th, 14th, 15th, 16th, 17th, 18th, 19th, 21st, 22nd, 23rd, 24th, 25th, 26th, 27th, 29th, 31st. January 2025 under 180 degrees Fahrenheit Records-Breakfast Rinse cycle: 6th, 7th, 9th, 10th, 11th, 14th, 15th, 16th, 17th, 19th, 20th, 21st, 22nd, 23rd, 24th, 25th, 26th, 27th, 28th, 29th, 31st. January 2025 under 150 degrees Fahrenheit Records-Lunch Wash cycle: 5th, 7th, 8th, 9th, 10th, 11th, 12th, 14th, 15th, 16th, 17th, 18th, 19th, 20th, 21st, 22nd, 23rd, 24th, 25th, 26th, 27th, 28th, 29th, 31st. January 2025 under 180 degrees Fahrenheit Records-Lunch Rinse cycle: 7th, 8th, 9th, 11th, 15th, 16th 17th, 19th, 21st, 22nd, 23rd, 26th, 27th, 29th, 31st. January 2025 under 150 degrees Fahrenheit Records-Dinner Wash cycle: 1st, 3rd, 4th, 5th, 6th, 7th, 10th, 11th, 16th, 17th, 18th, 19th, 20th, 23rd, 24th, 25th, 26th, 28th, 29th, 30th, 31st. January 2025 under 180 degrees Fahrenheit Records-Dinner Rinse cycle: 1st, 5th, 10th, 11th, 17th, 20th, 21st, 24th, 25th, 28th, 29th, 31st. On 04/09/2025 at 9:00 AM, Staff I, Dietary Manager, said 155-165 degrees was what the wash cycle was ran at (wash cycle should be 150 degrees to ensure sanitization). When asked what the target temperature for the dishwasher rinse cycle was, Staff I said 175-180 degrees (rinse cycle should be 180 degrees to ensure sanitization). When shown the January 2025, February 2025, and March 2025 temperature logs, Staff I acknowledged the temperatures were repeatedly outside of the required ranges to ensure that kitchenware was properly sanitized. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 9:03 AM, Staff I, ran a cycle of the dishwasher with the a wash cycle temperature reading 139 degrees, and the rinse cycle temperature reading 175 degrees, both temperatures outside of sanitizing range. On 04/09/2025 at 10:27 AM, Staff I, Dietary Manager with Staff D, Regional [NAME] President present, said they had ECOLAB (Dishwasher maintenance representative) coming to do maintenance on the dishwasher the next day. Staff I said, for whatever reason you have to run it multiple times to get it to reach temperature. Reference WAC 388-97-1100 (3) .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on observations, interviews and record review, the facility failed to properly store oxygen equipment for 1 of 1 sampled resident (Resident 39) reviewed for oxygen, and to ensure staff performed hand hygiene for 1 of 1 dining room reviewed for dining services. The facility also failed to use personal protective equipment (PPE) in accordance with the Centers for Disease Control (CDC) guidelines when caring for residents on enhanced barrier precautions (EBP, a set of infection control measures that use gowns and gloves to reduce the spread of multidrug-resistant organisms (MDROs)) for 1 of 3 sampled residents (Resident 26), and 1 of 3 kitchen staff members (Staff I) reviewed for infection control. Additionally, the facility failed to handle, store, and transport linens appropriately for laundry services reviewed for infection control. These failures placed residents at risk for facility acquired infections, spread of organisms and MDROs, contamination, related health complications, and a decreased quality of life. Findings included . The facility provided policy titled, Hand Hygiene, reviewed 06/03/2024, documented Hand Hygiene (HH) refers to a general term that applies to hand washing, antiseptic hand wash, and alcohol-based hand rub. This policy further directs an associate to perform hand hygiene before and after contact with the resident and after contact with objects and surfaces in the resident enviorment. <Oxygen Equipment Storage> Resident 39 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS, an assessment tool), dated 03/08/2025, documented Resident 39 was cognitively intact and was receiving oxygen therapy. On 04/07/2025 at 2:43 PM, Resident 39 was sitting in their wheelchair.Staff K, Housekeeping, entered Resident 39's room to assist Resident 39 in being able to hear and answer interview questions. Staff K removed Resident 39's nasal cannula (NC, a medical device used to deliver supplemental oxygen or increased airflow to the nostrils) and set it on the floor between Resident 39 and the bed. After transferring Resident 39 to the portable oxygen machine located on the back of Resident 39's chair, Staff K was asked about the NC and tubing storage. Staff K picked up the NC tubing off the floor, wrapped it around their hand and then placed it on the top, of the inside of the oxygen concentrator, and said this was where the NC tubing was usually stored when it was not in use. Staff K said they would step out of the room and let Resident 39 finish the interview questions. Before Staff K exited the room, Staff K, when asked about the NC and tubing being placed on the floor, said they should not have placed the NC on the floor. When asked about storing the NC after it had been on the floor, Staff K said the tubing should not have been placed there. At 2:52 PM, Staff K returned to Resident 39's room with a sealed package containing and new NC and oxygen tubing. Staff K replaced the NC, but did not wipe down the oxygen concentrator before replacing the NC and oxygen tubing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/10/2025 at 9:57 AM, Staff F, Resident Care Manager, said all oxygen tubing, including NC and tubing, should be stored in a clean bag and placed on the oxygen concentrator. Staff F said oxygen tubing was not to be draped over the furniture. When the observation was explained, regarding the NC being placed on the floor, Staff F said none of that should have happened, the NC should have been placed on the floor, the oxygen tubing should not have been stored in the handle of the oxygen concentrator and the machine should have been wiped down before replacing the oxygen tubing. At 11:52 AM, Staff B, Director of Nursing Services, said all oxygen equipment should be stored in the storage bags and oxygen tubing was changed weekly. When the observation was explained, regarding the NC being placed on the floor and improperly stored, Staff B said the NC being placed on the floor and stored incorrectly was not acceptable and the oxygen concentrator should have been wiped down. <Failure to perform hand hygiene> During the following observations of dining room service Staff L, Activity Assistant, missed opportunities to perform hand hygiene (HH) as follows: On 04/07/2025 at 11:54 AM, Staff L delivered two drinks to a table, picked up a wet floor sign, and then pushed her eyeglasses up on her nose (missed opportunity for HH). Staff L picked up cups from the drink cart, placed them back down on the drink cart, went to a cupboard, retrieved linens and then placed the linens on the cart on resident food trays. Staff L pushed up her eyeglasses on her nose (missed opportunity for HH), opened a door on the drink cart, pushed eyeglasses up on her nose (missed opportunity for HH) and went to the cupboard and got more linens out. Staff L then set the linens on the cart on resident food trays, pushed up her eyeglasses on her nose (missed opportunity for HH), closed a door on the drink cart, and touched here eyeglasses again. Staff L stepped into the kitchen doorway, walked to a food tray on a side table, picked up a plate of food and delivered it to a resident. Staff L pushed her eyeglasses up on her nose (missed opportunity for HH) and exited the dining room. At 12:08 PM, Staff L returned to the dining room with no HH observed upon entering dining room, pushed eyeglasses up on her nose (missed opportunity for HH), then picked up a plate of food and delivered it to a resident. Staff L pushed her eyeglasses up on her nose (missed opportunity for HH), then picked up another plate of food, a dessert plate, and a bag of chips and delivered these to another resident. Staff L went to the drink cart, opened a drawer, got packets of condiments and delivered to a resident. Staff L pushed her eyeglasses up (missed opportunity for HH), went to the kitchen and took a plate of food from on top of the steam table, and delivered it to another resident. Staff L went to the kitchen doorway, put her hands in her pants pockets, removed her hands from her pockets, and then pushed up her eyeglasses on her nose (missed opportunity for HH). Staff L asked kitchen staff for parmesan cheese, received a plastic cup of parmesan cheese and delivered it to a resident, then went back to the kitchen and picked up a plate of food and delivered it to another resident. On 04/11/2025 at 3:06 PM, Staff I, Dietary Manager, when asked if staff should perform HH after touching self or eyeglasses said, absolutely, after every time they touch themselves or anything on their person. Staff I said the dining room observations of lack of HH did not meet his expectations. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505306	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Port Townsend	751 Kearney Street Port Townsend, WA 98368

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/11/2025 at 3:08 PM, Staff E, Infection Preventionist (IP), when asked her expectations of staff performing HH while serving food and drinks, said she would have to look at the policy. When asked if she would expect HH in between staff touching their eyeglasses or self then serving food, said, yes, my expectation was that they would be following policy. <EBP> Resident 26 was admitted to the facility on [DATE]. Resident 26's admission MDS, dated [DATE] showed they were cognitively intact and had a urinary catheter (thin tube that drains urine). Resident 26 was on EBP for having a urinary catheter. On 04/11/2025 at 1:30 PM, Staff M, Certified Nursing Assistant, was observed to provide catheter care without wearing a gown. At 1:45 PM, Staff M, when asked about EBP said a gown should be worn. Staff M also acknowledged they did not hand hygiene with every glove change. At 2:17 PM, Staff E, IP, said a gown should have been worn for catheter care for Resident 26, and their expectation for EBP was that a gown and gloves would be worn during high contact resident care activities. <Laundry Services> On 04/07/2025 at 1:47 PM, Staff N, Laundry Aide, was observed to move a linen cart down the hall with one side of cart exposed/open, with the cover draped over the top of the cart and with dirty hangers on top it. Staff N was observed to come out of a room, to put dirty hangers on top of the cart, to grab a clean blanket from the linen cart, and to go into a different room. Then Staff N gathered hangers to remove from the room, was seen to have touched the wheelchair in the room, left the room, put dirty hangers on the linen cart, and then touched clothes for the next resident from inside of the linen cart. Staff N was not observed to hand hygiene as they left the rooms. At 2:01 PM, when asked when they should hand sanitize, Staff N said between residents, when handing out clothes, and when handling dirty laundry. With the dirty hangers on top of the linen cart, Staff N reported they could not close the cart. On 04/10/2025 at 12:28 PM, when informed of the observation of the linen cart going down the hallway with one side open, Staff P, Director of Environmental Services, said, no it should not have been open while moving down the hallway, once it leaves the laundry room it was to remain closed and opened only for the immediate room. When asked about the storage of dirty hangers on top of the cart, Staff P showed that the dirty hangers were normally kept in the same cart as the clean but divided by clean/dirty. When asked if they should store dirty and clean in the same linen cart at the same time, Staff P said, no we should not have dirty and clean together. When asked about the observation of no hand hygiene between dirty and clean, Staff P said they have now in-serviced the housekeeping staff on hand hygiene. Reference WAC 388-97-1320 (1)(c),(2)(a)(b),(3) .