

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505519	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/25/2025
NAME OF PROVIDER OR SUPPLIER  Benson Heights Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  22410 Benson Road SE Kent, WA 98031	

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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>47836</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents were provided informed consent (ensuring an explanation of the risks and benefits were provided) for the use of bed rails and/or the bed against a wall for 3 of 6 residents (Residents 63, 4, &amp; 70) reviewed for bed rails/bed against the wall. This failure placed residents at risk for loss of autonomy, entrapment, injury, and loss of the opportunity for alternative treatment options.</p> <p>Findings included .</p> <p>&lt;Policy&gt;</p> <p>According to a facility policy titled, Bed Rails, dated 02/2018, showed the facility would inform the resident or resident representative of the risks and benefits of bed rails prior to installation of the rails and obtain consent from the resident or the resident representative.</p> <p>&lt;Resident 63&gt;</p> <p>Review of a 01/10/2025 Admission Minimum Data Set (MDS - an assessment tool) Resident 63 had no bed rails installed on their bed. The MDS showed Resident 63 had no memory impairment. The MDS showed Resident 63 had diagnoses of, but not limited to, general muscle weakness, unsteadiness on feet, and other abnormalities of gait and mobility.</p> <p>Review of Resident 63's at risk for activity of daily living self-care performance deficit Care Plan (CP) showed an intervention of assist rail for bed mobility dated 07/17/2024.</p> <p>Observation on 02/18/2025 at 10:08 AM showed a bed rail on the right side of Resident 63's bed.</p> <p>In an interview on 02/24/2025 at 1:59 PM Staff E (Unit Manager) stated they did not obtain consent from Resident 63 for the quarter rail to the right side of their bed but should have. Staff E stated it was important to obtain consent prior to installation of bed rails to ensure the resident can use them safely and wants them.</p> <p>&lt;Resident 4&gt;</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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a 01/17/2025 Admission MDS Resident 4 had no restraints used to their bed. The MDS showed Resident 4 had no memory impairment. The MDS showed Resident 4 had diagnoses of, but not limited to, morbid obesity and a history of a stroke.</p> <p>Review of Resident 4's CP showed the bed against the wall was not identified as of 02/18/2025.</p> <p>Observation on 02/19/2025 at 10:19 AM showed Resident 4's right side of their bed against the wall.</p> <p>In an interview on 02/24/2025 at 1:59 PM Staff E stated the facility did not obtain Resident 4's consent to have their bed against the wall but should have. Staff E stated it was important to obtain consent prior to placing the bed against the wall to ensure the resident was informed and had a say in their care.</p> <p>&lt;Resident 70&gt;</p> <p>Review of a 10/01/2024 Admission MDS Resident 70 had no restraints used to their bed. The MDS showed Resident 4 had no memory impairment. The MDS showed Resident 70 had diagnoses of, but not limited to, lack of coordination, general muscle weakness, and need for assistance with personal care.</p> <p>Review of Resident 70's CP showed the bed against the wall was not identified as of 02/18/2025.</p> <p>Observation on 02/19/2025 at 7:39 AM showed Resident 70's left side of bed against the wall.</p> <p>In an interview on 02/24/2025 at 1:45 PM Staff E stated the facility did not obtain consent from Resident 70 for the bed against the wall but should have. Staff E stated it was important to obtain consent prior to placing the bed against the wall to ensure the resident was informed and had a say in their care.</p> <p>Refer to F656 - develop/implement comprehensive care plan</p> <p>Refer to F658 - services provided meet professional standards</p> <p>Refer to F689 - free of accident hazards</p> <p>REFERENCE: WAC 388-97-0260.</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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>47836</p> <p>Based on record review and interview the facility failed to ensure residents received required written notices at the time of transfer/discharge, or as soon as practicable for 3 of 3 residents (Residents 22, 63, &amp; 82) reviewed for hospitalization s and 1 supplemental resident (Resident 20) reviewed. The failure to ensure written transfer notifications were provided to residents and/or their representatives, in a language and manner they understood, placed residents at risk for not having an opportunity to make an informed decision about the transfer/discharge.</p> <p>Findings included .</p> <p>&lt;Policy&gt;</p> <p>According to the facility policy titled, Notice Requirements Before Transfer/Discharge, dated 07/2018, the facility would provide the resident and/or their representative, in writing, the reasons for the move in a language and manner they understood prior to the transfer/discharge. The policy showed the written notice would include the reason for transfer/discharge, the effective date, the location, a statement of the resident's rights to appeal, contact information for the office of the state long term ombudsman, contact information for the agency responsible for the protection and advocacy of individuals with developmental disabilities, and contact information for the agency responsible for the protection and advocacy of individual with a mental disorder.</p> <p>&lt;Resident 22&gt;</p> <p>Review of a 03/16/2024 Discharge Return Anticipated Minimum Data Set (MDS- an assessment tool) showed Resident 22 was discharged to an acute care hospital on 03/16/2024. The MDS showed Resident 22 had no memory impairment.</p> <p>Review of Resident 22's health records showed a 03/16/2024 written transfer notification form with only Staff M's (Registered Nurse) signature, no witness signature, and Resident 22's name written in, not signed by the resident.</p> <p>In an interview on 02/19/2025 at 9:22 AM Resident 22 stated they went to the hospital on 03/16/2024 for a fall.</p> <p>In an interview on 02/24/2025 at 1:45 PM Staff E (Unit Manager) stated Resident 22's written transfer notification should have been witnessed since the resident was unable to sign. Staff E stated the written transfer notification should be provided to Resident 22 or their representative, to ensure the resident/representative understood their rights.</p> <p>&lt;Resident 63&gt;</p> <p>Review of a 12/31/2024 Discharge Return Anticipated MDS showed Resident 63 was discharged to an acute care hospital on 12/31/2024. The MDS showed Resident 63 had no memory impairment.</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 63's health records showed a 12/31/2024 written transfer notification form with only Staff E's signature, no witness signature, and Resident 63's representative name written in, not signed by the resident or representative.</p> <p>In an interview on 02/18/2025 at 10:02 AM Resident 63 stated they went to the hospital on 12/31/202.</p> <p>In an interview on 02/24/2025 at 1:37 PM Staff E stated they complete the written transfer notification and gave the notice to the social service staff to send to the representative. Staff E stated they were not informed they were responsible for giving a physical copy to the residents or their representatives. Staff E stated it was important to provide a copy, so the resident or resident representative had instructions about their rights to appeal the transfer/discharge if they wished to do so.</p> <p>&lt;Resident 82&gt;</p> <p>Review of a 02/07/2025 Discharge Return Anticipated MDS showed Resident 82 was discharged to an acute care hospital on 02/07/2025. The MDS showed Resident 82 had no memory impairment.</p> <p>Review of Resident 82's health records showed a 02/07/2025 written transfer notification form with only Staff E's signature, no witness signature, and Resident 63's representative name written in, not signed by the resident or representative.</p> <p>In an interview on 02/24/2025 at 11:26 AM Staff D (Social Service Director) stated there wasn't a written transfer notification in Resident 82's health records for the transfer on 02/07/2025 but should be. Staff D went to medical records department and Staff N (Medical Records) stated they did not have a written transfer notification for Resident 82's transfer to hospital on 02/07/2025. Staff stated the only other place it could be, if one was done, would be in the scanning bin at the nurse's station. Staff D checked the scanning bin and Resident 82's written transfer notification form was not in there. Staff D stated the nurses were responsible for ensuring the resident or representative received the physical copy in writing. Staff D stated it was important to make sure the resident or representative received a copy in writing because the form had instructions on what to do and how to appeal the transfer/discharge.</p> <p>In an interview on 02/24/2025 at 1:37 PM Staff E stated they were unaware it was their responsibility to mail a written transfer notification and thought the social service department mailed the representative a copy. Staff E stated it was important to provide a written transfer notification for resident rights to be informed about the transfer and to provide them the instructions on how to appeal.</p> <p>50511</p> <p>&lt;Resident 20&gt;</p> <p>According to a 02/05/2025 Admission MDS Resident 20 had no memory impairment. The MDS showed Resident 20 had an indwelling urinary catheter, history of urinary tract infections, was partially paralyzed, and had a behavior disorder.</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of a Nursing Home Transfer or Discharge Notice dated 02/08/2025 showed Resident 20 was transferred to the hospital due to a higher level of care needed, low blood pressure, high heart rate and a fever. Review of Resident 20's health records showed the 02/08/2025 written transfer notification form with only Staff Q's (Licensed Practical Nurse) signature, no witness signature, and Resident 20's name written in, not signed by the resident. Resident 20's records also showed a transfer to an acute care hospital on 02/20/2025 for a stomachache with a written transfer notification with Staff R (Registered Nurse) signature, no witness signature, and Resident 20's name written in, not signed by the resident.</p> <p>In an interview on 02/25/2025 at 1:17 PM Staff A (Administrator) stated whenever a resident was transferred to the hospital the nurse transferring the resident would complete a notification of transfer/discharge form. Staff A stated staff should get the resident to sign the form, if a resident was not alert, the facility would provide follow up and notify the family. Staff A stated nurses were responsible for filling out the form and social services would be responsible for follow up right away to make sure the form was provided to the resident and/or their representative.</p> <p>REFERENCE: WAC 388-97-0120(2)(a-d).</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42203</b></p> <p>Based on interview and record review, the facility failed to ensure a level II Preadmission Screening and Resident Review (PASRR- a mental health screening required prior to nursing home admission) evaluation was completed and/or incorporated into the Care Plan (CP) for 4 of 6 residents (Residents 61, 22, 82, &amp; 20) reviewed for PASRR. This failure placed residents at risk for unmet mental health care needs.</p> <p>Findings included:</p> <p>&lt;Facility Policy&gt;</p> <p>According to the facility's 11/2017 PASRR policy, a PASRR screening must be completed prior to admission. The policy showed for residents assessed to need Level II services, the facility would incorporate the recommendations into the resident's CP.</p> <p>&lt;Resident 61&gt;</p> <p>According to the 11/14/2024 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 61 admitted to the facility from the hospital on 07/16/2022 and was assessed with a severe memory impairment. The MDS showed Resident 61 had diagnoses including dementia and three mental health diagnoses, and needed to use antipsychotic and anti-anxiety medications.</p> <p>Record review showed three Level I PASRR screenings on file for Resident 61: a 07/18/2022 Level I screening showing Level II services were not required, an 08/24/2022 Level I PASRR showing a Level II referral was necessary, and an 08/18/2023 Level I PASRR also showing Level II services were required.</p> <p>Record review showed there was no Level II PASRR evaluation on file for Resident 61. Resident 61's record included a 02/05/2018 Level II PASRR invalidation from a previous unaffiliated nursing home admission.</p> <p>In an interview on 02/24/2025 at 2:07 PM Staff D (Social Services Director) stated if the Level I PASRR showed a resident required further screening for Level II services, it was social services responsibility to follow as needed. Staff D stated they believed there was a Level II invalidation on file but upon review of the document acknowledged it did not address Resident 61's stay at this facility. Staff D stated there was no Level II determination on file for the 08/18/2023 Level I PASRR screening. Staff D checked their email and stated the last time they reached out to the PASRR office for follow up was on 02/27/2024.</p> <p>47836</p> <p>&lt;Resident 22&gt;</p> <p>(continued on next page)</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a 07/19/2024 Admission MDS Resident 22 had no memory impairment. The MDS showed Resident 22 had diagnoses of, but not limited to, depression and schizophrenia (chronic mental health condition with disruption in thought processes, perceptions and behavior).</p> <p>Review of Resident 22's CP showed a PASRR level I with Serious Mental Illness (SMI). The CP showed an intervention for social service to review the PASRR quarterly and as needed.</p> <p>Review of Resident 22's health records showed a 08/18/2023 PASRR level I stating a level 2 PASRR was required for SMI. Resident 22's health records had no documentation of a level II PASRR being done.</p> <p>In an interview on 02/24/2025 at 10:54 AM Staff D stated there was no evidence of the level II PASRR in Resident 22's health records for the 08/18/2023 PASRR level I with SMI. Staff D stated it was important to complete the PASRR level II to obtain the consultants recommendations for the resident's mental health care.</p> <p>&lt;Resident 82&gt;</p> <p>Review of a 12/16/2024 Significant Change MDS Resident 82 had no memory impairment. The MDS showed Resident 82 had diagnoses of, but not limited to, depression, Post Traumatic Stress Disorder (PTSD), and psychotic disorder.</p> <p>Review of a 10/24/2024 PASRR CP showed Resident 82 had a PASRR level II. The CP showed staff were to follow the recommendations of the level II PASRR.</p> <p>Review of Resident 82's health records showed a 08/29/2024 PASRR level I documenting a level II PASRR was required for SMI. Resident 82's health records had no documentation of a level II PASRR being done. Resident 82's level I PASRR showed they had a new diagnosis of PTSD.</p> <p>In an interview on 02/24/2025 at 10:54 AM Staff D stated there was no evidence of the level II PASRR in Resident 82's health records for the 08/29/2024 PASRR level I with SMI and new diagnosis of PTSD. Staff D stated it was important to complete the PASRR level II to obtain the consultants recommendations for the resident's mental health care.</p> <p>50511</p> <p>&lt;Resident 20&gt;</p> <p>According to the 02/05/2025 Admission MDS, Resident 20 admitted to the facility on [DATE]. The MDS showed Resident 20 diagnoses of a chronic mental health condition, hallucinations, delusions, verbal behavior towards others and Resident 20's behavior significantly interfered with care.</p> <p>Review of the 01/29/2025 level I PASRR showed Resident 20 had SMI indicators for personality and anxiety disorders. A level II evaluation referral was indicated on the PASSR form due to SMI. Review of Resident 20's medical records did not show a level II PASRR with recommendations for the resident's behaviors was completed.</p> <p>(continued on next page)</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 02/25/2025 at 2:50 PM, Staff D stated the level II PASRR referral should have been completed by the hospital before Resident 20 was admitted to the facility. Staff D stated they follow up to make sure the referral was made to the correct authority. Staff D stated since Resident 20 discharged in and out of the facility on two occasions they were not able to follow up to determine if a level II PASRR referral was made. Staff D stated that a PASSR level II referral was important to determine the level of care needed for the resident.</p> <p>REFERENCE: WAC 388-97-1915(4).</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>42203</p> <p>Based on observation, interview, and record review the facility failed to develop and/or implement a comprehensive Care Plan (CP) for 6 of 18 residents (Residents 34, 10, 4, 63, 70 &amp; 38). This failure placed residents at risk for unmet care needs, frustration, and other negative health outcomes.</p> <p>Findings included .</p> <p>&lt;Resident 34&gt;</p> <p>According to the 11/20/2024 Admission Minimum Data Set (MDS - an assessment tool) Resident 34 had intact memory and medically complex diagnoses including a history of stroke, but no seizure/epilepsy diagnosis. The MDS showed Resident 34 used an anticonvulsant (anti-seizure) medication.</p> <p>According to a 12/02/2024 physician's progress note, Resident 34 had metabolic encephalopathy (a change in how the brain works due to an underlying condition) in part due to a seizure disorder.</p> <p>Record review showed a 02/15/2025 physician's order for an anticonvulsant medication at 750 Milligrams (MG) twice a day for a seizure disorder, and a prior 11/13/2024 order for the same medication with the same schedule for spinal injuries.</p> <p>Review of Resident 34's comprehensive CP showed no CP developed addressing the resident's anticonvulsant use.</p> <p>In an interview on 02/25/2025 at 9:45 AM, Staff B (Director of Nursing) stated the anticonvulsant medication was ordered to treat a seizure disorder. Staff B stated the facility should have but did not develop a CP to address the use of the anticonvulsant medication.</p> <p>&lt;Resident 10&gt;</p> <p>According to the 12/20/2024 Quarterly MDS, Resident 10 had diagnoses including difficulty voiding urine and dementia. The MDS showed Resident 10 used a urinary catheter (tubing to help with voiding urine) and had two Stage-3 Pressure Ulcers (PU) and one Stage-4 PU.</p> <p>Observation on 02/19/2025 at 8:52 AM showed a sign outside Resident 10's room indicating staff were required to use Enhanced Barrier Precautions (EBP - precautions such as gloves, gowns, eye protection etc. required when providing certain types of close contact care such as changing a resident.)</p> <p>Record review showed a 02/05/2025 physician's order showing Resident 10 required a urinary catheter related to their difficulty urinating. Resident 10 also had a 10/04/2023 order for wound care for a PU on their left buttock, and a 02/17/2025 order for wound care to their right thigh.</p> <p>(continued on next page)</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>According to the 12/20/2024 EBP CP staff should use EBP when providing high-contact care including ostomy (an artificial opening into the body) care and for device care/use including a central line (a type of intravenous access), feeding tube, tracheostomy (a whole in the throat to open airways), and ventilator (a large breathing apparatus) care/use.</p> <p>In an interview on 02/25/2025 at 11:12 AM Staff B (Director of Nursing) stated Resident 10 did not have any kind of ostomy including a tracheotomy, a central line, feeding tube, or a ventilator. Staff B stated the CP needed to be individualized to reflect Resident 10's PU and catheter status as the reason for EBP.</p> <p>47836</p> <p>&lt;Resident 4&gt;</p> <p>Review of the 01/17/2025 Admission MDS Resident 4 had no memory impairment. The MDS showed Resident 4 had no restraints used on their bed. The MDS showed Resident 4 had a history of a stroke.</p> <p>Observation on 02/19/2025 at 10:19 AM showed Resident 4's right side of bed against the wall.</p> <p>Review of Resident 4's health records on 02/23/2025 showed no CP for the right side of their bed against the wall.</p> <p>In an interview on 02/24/2025 at 1:59 PM Staff E (Unit Manager) stated Resident 4's right side of bed was against the wall but there was not a CP for it. Staff E stated it was important to CP the bed against the wall for resident safety, to ensure staff were aware and monitoring the resident's safety.</p> <p>&lt;Resident 63&gt;</p> <p>Review of the 01/10/2025 Admission MDS Resident 63 had no memory impairment. The MDS showed Resident 63 had no restraints used on their bed. The MDS showed Resident 63 had diagnoses of, but not limited to, general muscle weakness and unsteadiness on feet.</p> <p>Observation on 02/18/2025 at 10:08 AM showed Resident 63's left side of bed against the wall.</p> <p>Review of Resident 63's health records on 02/23/2025 showed no CP for the left side of their bed against the wall.</p> <p>In an interview on 02/24/2025 at 1:59 PM Staff E (Unit Manager) stated Resident 63's left side of bed was against the wall but there was not a CP for the bed against the wall. Staff E stated it was important to CP the bed against the wall for resident safety, to ensure staff were aware and monitoring the resident's safety.</p> <p>&lt;Resident 70&gt;</p> <p>(continued on next page)</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>Review of the 10/01/2024 Admission MDS Resident 70 had no memory impairment. The MDS showed Resident 70 had no restraints used on their bed. The MDS showed Resident 70 had difficulty hearing. The MDS showed Resident 70 had diagnoses of, but not limited to, general muscle weakness, difficulty walking, and lack of coordination.</p> <p>During an observation and interview on 02/19/2025 at 7:32 AM showed Resident 70's left side of bed against the wall. Resident 70 showed symptoms of difficulty hearing and stated they could not hear out of their left ear.</p> <p>Review of Resident 70's health records on 02/23/2025 showed no CP for the left side of their bed against the wall or the inability to hear with their left ear.</p> <p>In an interview on 02/24/2025 at 1:59 PM Staff E (Unit Manager) stated Resident 70's left side of bed was against the wall but there was not a CP for it. Staff E stated it was important to CP the bed against the wall for resident safety, to ensure staff were aware and monitoring the resident's safety. Staff E reviewed the MDS showing Resident 70's difficulty hearing and stated they did not have a hard of hearing CP but should, so staff knew how to best communicate with them and ensure they heard what staff was saying.</p> <p>50511</p> <p>&lt;Resident 38&gt;</p> <p>&lt;Seizure Medication&gt;</p> <p>According to the 01/02/2025 Quarterly MDS, Resident 38 medical conditions included respiratory failure, history of falls and a seizure disorder.</p> <p>Review of Resident 38's revised 07/22/2024 Seizure Disorder CP showed staff were to give seizure medications as ordered and to monitor for side effects. The CP did not identify what side effects staff were to monitor and did not show drug toxicity side effects for one of Resident 38's seizure medications that required lab monitoring.</p> <p>Review of the February Medication Administration Record (MAR) and February monitors record did not identify side effects or drug toxicity symptoms staff were to observe for their seizure medication.</p> <p>&lt;Antibiotic Medication&gt;</p> <p>Review of Resident 38's revised 07/22/2024 history of Pneumonia (lung infection) related to aspiration (food or liquid accidentally enters the lungs) CP showed staff were to give medications as ordered and to monitor side effects and effectiveness. The CP did not indicate Resident 38 had taken antibiotics due to acute respiratory illness and did not indicate symptoms or dietary adjustments to observe for while taking an antibiotic.</p> <p>Review of February 2025 MAR showed an order dated 02/20/2025 for an antibiotic medication, 500 Milligrams (mg) once a day for acute respiratory illness for 7 days. The MAR did not indicate what signs and symptoms to observe while Resident 38 was on the antibiotic medication.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Benson Heights Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  22410 Benson Road SE Kent, WA 98031	

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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>Review of June 2024 MAR showed an order dated 06/08/2024 to give an antibiotic medication, 600 mg twice a day for a respiratory illness for 5 days. The MAR did not indicate what signs and symptoms to observe while Resident 38 was on the antibiotic medication.</p> <p>In an interview on 02/25/2025 at 11:12 AM, Staff F (Unit Manager) stated antibiotic medication and side effects and side effects of the seizure medication should be listed on the CP but was not. Staff F stated this was important for tracking purposes and to make sure Resident 38 was on the right treatment for their illness and care.</p> <p>In an interview on 02/25/2025 at 2:23 PM, Staff B (Director of Nursing) stated antibiotic monitoring should be on the CP but was not. Staff B stated seizure medication should be on the CP because of risk of drug toxicity but was not.</p> <p>Refer to F552 - right to be informed</p> <p>Refer to F658 - services provided meet professional standards</p> <p>Refer to F689 - free of accident hazards</p> <p>REFERENCE: WAC 388-97-1020(1),(2)(a).</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>47836</p> <p>Based on record review and interview the facility failed to ensure physician orders for 3 of 3 residents (Residents 4, 22, &amp; 71) reviewed for accident hazards, 1 of 2 residents (Resident 63) reviewed for physical restraints, a physician order for 1 of 4 residents (Resident 22) reviewed for respiratory care, and 1 of 5 residents reviewed for nutrition (Resident 38) were obtained, clarified, and/or implemented. These failures placed residents at risk for potential adverse effects, unmet needs, complications, and diminished quality of life.</p> <p>Findings included .</p> <p>&lt;Policy&gt;</p> <p>According to a facility policy titled, Respiratory Care/Tracheostomy Care &amp; Suctioning, dated 07/2018, the facility would provide residents with necessary respiratory care and services that were in accordance with professional standards of practice.</p> <p>&lt;Resident 4&gt;</p> <p>Review of the 01/17/2025 Admission Minimum Data Set (MDS - an assessment tool) Resident 4 had no memory impairment. The MDS showed Resident 4 had no restraints used on their bed. The MDS showed Resident 4 had a history of a stroke.</p> <p>Observation on 02/19/2025 at 10:19 AM showed Resident 4's right side of bed against the wall.</p> <p>Review of Resident 4's health records on 02/23/2025 showed no physician order for the right side of their bed against the wall.</p> <p>In an interview on 02/24/2025 at 1:59 PM Staff E (Unit Manager) stated Resident 4's right side of bed was against the wall but there wasn't a physician order for this. Staff E stated it was important to have a physician order for the bed against the wall to ensure this was an appropriate plan of care for the resident.</p> <p>&lt;Resident 22&gt;</p> <p>Review of the 07/19/2024 Annual MDS Resident 22 had no memory impairment. The MDS showed Resident 22 had no restraints used on their bed. The MDS showed Resident 22 had diagnoses of, but not limited to, general muscle weakness, restless leg syndrome, and difficulty walking.</p> <p>Observation on 02/20/2025 at 1:26 PM showed Resident 22's left side of bed against the wall.</p> <p>In an interview and observations on 02/21/2025 at 9:03 AM Resident 22's oxygen tubing showed a date of 02/13/2025. Staff F (Unit Manager) stated oxygen tubing should be changed weekly. Staff F reviewed Resident 22's health records and stated they did not have a physician order to change the oxygen tubing weekly per facility policy but should have. Staff F stated it was important to change the oxygen tubing weekly for infection prevention.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 22's health records on 02/23/2025 showed no physician order for the left side of their bed against the wall.</p> <p>In an interview on 02/25/2025 at 8:45 AM Staff F stated Resident 22's left side of bed was against the wall but there wasn't a physician order for this. Staff F stated it was important to have a physician order for the bed against the wall to ensure a physician guided plan of care for the resident.</p> <p>&lt;Resident 63&gt;</p> <p>Review of the 01/10/2025 Admission MDS Resident 63 had no memory impairment. The MDS showed Resident 63 had no restraints used on their bed. The MDS showed Resident 63 had diagnoses of, but not limited to, general muscle weakness and unsteadiness on feet.</p> <p>Observation on 02/18/2025 at 10:08 AM showed Resident 63's left side of bed against the wall.</p> <p>Review of Resident 63's health records on 02/23/2025 showed no physician order for the left side of their bed against the wall.</p> <p>In an interview on 02/24/2025 at 1:59 PM Staff E stated Resident 63's left side of bed was against the wall but there wasn't a physician order for this. Staff E stated it was important to have a physician order for the bed against the wall to ensure this was an appropriate plan of care for the resident.</p> <p>&lt;Resident 71&gt;</p> <p>Review of the 07/29/2024 Annual MDS Resident 71 had no memory impairment. The MDS showed Resident 71 had no restraints used on their bed. The MDS showed Resident 71 had diagnosis of, but not limited to, a right leg displaced fracture.</p> <p>Observation on 02/18/2025 at 10:08 AM showed Resident 71's right side of bed against the wall.</p> <p>Review of Resident 71's health records on 02/23/2025 showed no physician order for the right side of their bed against the wall.</p> <p>In an interview on 02/24/2025 at 2:08 PM Staff E stated Resident 71's left side of bed was against the wall but there wasn't a physician order for this. Staff E stated it was important to have a physician order for the bed against the wall to ensure this was an appropriate plan of care for the resident.</p> <p>42203</p> <p>&lt;Resident 34&gt;</p> <p>According to the 11/20/2024 Admission MDS, Resident 34 had medically complex diagnoses including a spinal fracture and a history of falling. The MDS showed Resident 34 had frequent pain that affected their sleep and ability to participate in activities and therapy.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review showed two physician orders for a pain medication patch: a 02/18/2025 physician's order for a pain medication patch to be placed on Resident 34's lower back in the evening and removed at bedtime for pain, and a 02/19/2025 physician's order for the same pain medication patch to be applied in the morning and removed in the afternoon. The orders did not include the strength of the painkiller required.</p> <p>In an interview on 02/25/2025 at 9:32 AM, Staff B (Director of Nursing) stated they expected orders to be clarified when unclear. In the same interview at 9:45 AM, Staff B reviewed the pain medication patch orders and stated they should include the strength of the medication but did not.</p> <p>50511</p> <p>Resident &lt;38&gt;</p> <p>According to the revised 10/7/2024 Quarterly MDS, Resident 38 had a history of a stroke, respiratory failure, and difficulty swallowing. The MDS showed Resident 38 needed substantial assistance with eating and needed a pureed food and thickened liquid diet.</p> <p>Review of a revised 10/14/2024 Nutritional Problem Care Plan (CP) showed Resident 38 needed one on one supervision with meals to prevent choking and aspiration and to promote a consistent intake.</p> <p>Review of Resident 38's health record showed a physician order dated 02/20/2025 for a swallow evaluation with treatment related to possible aspiration. Health record did show a swallow evaluation had been completed.</p> <p>Observation on 2/20/2025 at 11:32 AM showed Resident 38 sitting in wheelchair in the dining room. Observed Resident 38 had a food tray of pureed foods and thickened juice, coffee and water. An Unidentified Certified Nursing Aid (CNA) assisted Resident 38 with feeding, resident 38 began coughing while eating.</p> <p>In an interview on 2/21/2025 at 8:44 AM Staff O (Certified Nursing Aid) stated while Resident 38 was being fed they began to cough.</p> <p>In an interview on 02/25/2025 at 11:06 AM Staff F (Unit Manager) stated the swallow evaluation ordered on 02/20/2025 did not occur. Staff F stated they expected the swallow evaluation to be done as soon as possible. Staff F stated the CP should also provide specific instructions on how to feed Resident 38 to avoid choking, but feeding details needed to be added after a swallow evaluation occurred.</p> <p>In an interview on 02/25/2025 at 2:19 PM Staff B (Director of Nursing) stated Resident 38 was at risk for aspiration while eating and a swallow evaluation was ordered on 2/20/2025, five days ago. Staff B stated a swallow evaluation should be set up within 48 to 72 hours of the order being received but was not.</p> <p>Refer to F552 - right to be informed</p> <p>Refer to F656 - develop/implement comprehensive care plan</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Refer to F689 - free of accident hazards</p> <p>REFERENCE: WAC 388-97-1620(2)(b)(i)(ii).</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>42203</p> <p>Based on observation, interview, and record review the facility failed to implement skin breakdown interventions for 1 of 6 residents (Resident 61) reviewed for positioning/mobility and failed to provide weight monitoring for 1 of 1 resident (Resident 82) reviewed for edema. The failure to ensure palm protectors were used as ordered (Resident 61) and weights monitored as required (Resident 82) placed residents at risk for skin breakdown, weight loss, weight gain, and other negative health outcomes.</p> <p>Findings included .</p> <p>&lt;Facility Policy&gt;</p> <p>According to the facility's 11/2017 Quality of Care -policy, for residents with non-pressure-related skin impairments, the facility would provide care and services consistent with professional standards to prevent skin breakdown. The policy showed the facility would provide preventative measures as needed to maintain skin integrity.</p> <p>According to an undated facility policy titled, Edema Management, interventions for heart failure may include monitoring weights.</p> <p>&lt;Resident 61&gt;</p> <p>According to the 11/14/2024 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 61 had a severe memory impairment and required total assistance with all daily routines. The MDS showed Resident 61 had diagnoses including dementia, seizures, malnutrition, and an altered mental state. The MDS showed Resident 61 required total assistance with all daily care and had open lesions.</p> <p>Review of the physician's orders showed a 12/18/2024 order to apply Therapy Carrot [a carrot-shaped, fabric, therapy tool used to create space in a hand that no longer opens freely] for 4 hours in each hand then switch to the other hand. Therapy carrots can be placed in one hand at a time as tolerated. every shift .</p> <p>According to the 12/18/2024 Potential for skin breakdown Care Plan (CP) nursing staff should place the Therapy Carrot in each hand for 4 hours per hand or as tolerated. The CP showed staff should place a Therapy Carrot in one hand at a time.</p> <p>Record review showed there was nowhere for nursing staff to document they placed the Therapy Carrot in either hand, how long Resident 61 tolerated the Therapy Carrot, or when the Therapy Carrot was removed.</p> <p>Observation on 02/18/2025 at 1:43 PM showed a sign above Resident 61's bed informing staff that the resident's previous sheepskin palm protector was discontinued and to now use the Therapy Carrot. There was no Therapy Carrot observed in place.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 02/24/2025 at 12:13 PM, 12:35 PM, and 01:17 PM showed no Therapy Carrot in either hand.</p> <p>In an interview on 02/25/2025 at 10:03 AM, Staff B (Director of Nursing) stated if a resident had a physician-ordered intervention to prevent skin break down, they expected the provision of the care to be documented. Staff B reviewed Resident 61's chart and stated there was not but should be a place for the nursing staff to document when they provided the Therapy Carrot. Staff B stated given how the order was written, Resident 61 should have the Therapy carrot in the middle of the day. Staff B then went over to Resident 61 and asked the resident if they could look at their hands. Staff B then examined Resident 61's hands and stated the Therapy Carrot should be but was not placed in one of Resident 61's hands.</p> <p>47836</p> <p>&lt;Resident 82&gt;</p> <p>Review of a 12/16/2024 Quarterly MDS Resident 82 had no memory impairment. The MDS showed Resident 82 received diuretic medication during the assessment period. The MDS showed Resident 82 had diagnoses of, but not limited to, heart failure and edema.</p> <p>Review of a 06/10/2024 heart failure CP showed the facility would monitor Resident 82's weight daily and monitor for lower extremity edema.</p> <p>Observation on 02/20/2025 at 1:57 PM showed Resident 82 had pitting edema (fluid in tissues that shows an indentation when pressed with a finger) to bilateral lower extremities.</p> <p>In an interview on 02/24/2025 at 9:12 AM Staff E (Unit Manager) stated Resident 82 had bilateral lower extremity edema. Staff E stated they were only obtaining Resident 82's weight weekly and should be monitoring it daily. Staff E stated it was important to monitor Resident 82's weight daily because excessive fluid retention could cause cardiac overload and fluid in the lungs.</p> <p>REFERENCE: WAC 388-97-1060(1).</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>47836</p> <p>Based on observation, record review, and interview, the facility failed to ensure safety assessments were completed for 3 of 6 residents (Residents 4, 63, &amp; 70) reviewed for bed against the wall/bed rails, failed to store chemicals and razors for 1 of 2 utility rooms (North Utility Room) and failed to supervise the leave of absence for 1 of 2 residents (Resident 90) reviewed for leave from the facility. Failure to complete safety assessments for the beds against the wall, store chemicals and razors safely, and supervise a resident at risk for safety while on a leave of absence placed residents at risk of entrapment and injury.</p> <p>Findings included .</p> <p>&lt;Policy&gt;</p> <p>According to a facility policy titled, Accident Hazards/Supervision/Devices, dated 07/2018, the facility would implement systems that addressed residents risk and environmental hazards to minimize the likelihood of accidents. The policy showed a potentially hazardous item or situations that was accessible to vulnerable residents would be considered hazardous. The policy showed hazardous materials would be contained to protect residents from exposure. The policy showed risks and benefits of devices which may pose an entrapment risk would be assessed prior to implementation of such devices. The policy showed the facility would use supervision as an intervention to mitigate accident risks. The facility would work with resident vulnerabilities to understand the reasons for their choices and discuss possible options and the Care Plan (CP) would be updated to honor the resident's choices while mitigating risks.</p> <p>According to a facility policy titled, Bed Rails, dated 02/2018, showed the facility would inform the resident or resident representative of the risks and benefits of bed rails prior to installation of the rails and obtain consent from the resident or the resident representative.</p> <p>&lt;Resident 4&gt;</p> <p>Review of a 01/17/2025 Admission Minimum Data Set (MDS - an assessment tool) showed Resident 4 had no restraints used on their bed. The MDS showed Resident 4 had no memory impairment. The MDS showed Resident 4 had diagnoses of, but not limited to, morbid obesity and a history of a stroke.</p> <p>Review on 02/19/2025 of Resident 4's health records showed no safety assessment for their right side of bed against the wall.</p> <p>Observation on 02/19/2025 at 10:19 AM showed Resident 4's right side of their bed against the wall.</p> <p>In an interview on 02/24/2025 at 1:59 PM Staff E (Unit Manager) stated the facility did not complete Resident 4's safety assessment prior to placing their bed against the wall but should have. Staff E stated it was important to complete the assessment prior to placing the resident's bed against the wall to ensure their safety.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>&lt;Resident 63&gt;</p> <p>Review of a 01/10/2025 Admission MDS Resident 63 had restraints to their bed. The MDS showed Resident 63 had no memory impairment. The MDS showed Resident 63 had diagnoses of, but not limited to, general muscle weakness, unsteadiness on feet, and other abnormalities of gait and mobility.</p> <p>Review on 02/18/2025 of Resident 63's health records showed no safety assessment for their left side of bed against the wall.</p> <p>Observation on 02/18/2025 at 10:08 AM showed Resident 63's left side of bed against the wall.</p> <p>In an interview on 02/24/2025 at 1:59 PM Staff E stated they did not complete a safety assessment for Resident 63's left side of bed against the wall but should have. Staff E stated it was important to complete the assessment prior to placing the resident's bed against the wall to ensure their safety.</p> <p>&lt;Resident 70&gt;</p> <p>Review of a 10/01/2024 Admission MDS Resident 70 had no restraints used to their bed. The MDS showed Resident 70 had no memory impairment. The MDS showed Resident 70 had diagnoses of, but not limited to, lack of coordination, general muscle weakness, and need for assistance with personal care.</p> <p>Review on 02/19/2025 of Resident 70's health records showed no safety assessment for their left side of bed against the wall.</p> <p>Observation on 02/19/2025 at 7:39 AM showed Resident 70's left side of bed against the wall.</p> <p>In an interview on 02/24/2025 at 1:45 PM Staff E stated they did not complete a safety assessment for Resident 70's left side of bed against the wall but should have. Staff E stated it was important to complete the assessment prior to placing the resident's bed against the wall to ensure their safety.</p> <p>&lt;North Utility Room&gt;</p> <p>Observation on and interview on 02/21/2025 at 8:30 AM showed the north utility room door unlocked. The north utility room had razors, hygiene supplies, and disinfectant cleaners stored in open cabinets. Staff E stated it should be kept locked but was not. Staff E stated the utility rooms should be kept locked for resident safety because they had chemicals and razors stored inside them that residents should not have open access to.</p> <p>50511</p> <p>&lt;Resident 90&gt;</p> <p>According to a 01/31/2025 Admission MDS Resident 90 had some memory impairment, history of a post-traumatic stress disorder, had a bone infection of the lower back and spine and a skin infection to the right lower leg.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>According to the 01/25/2025 Behavior CP, Resident 90 could exhibit a behavior concern related to post traumatic stress order and a history of substance abuse. The CP did not show interventions for Resident 90 leaving the facility unaccompanied.</p> <p>Review of a physician order 01/24/2025 showed Resident 90 could leave the facility with a responsible person with them.</p> <p>Interview on 02/21/2025 at 08:55 AM, Resident 90 stated that they left the facility at 4:30 PM and returned to the facility at 8:15 PM. Resident 90 stated they were told according to the facility policy they should be accompanied by a person when they left the facility. Resident 90 stated they did not have anybody with them when they left the facility and called a cab for a ride and wondered if the cab driver counted as a responsible person. Resident 90 stated they went out to go shopping and then went to another city to have a drink with a friend and then went to their apartment to check their mail. Resident 90 stated they told the staff that they got permission to leave without anyone accompanying them when they signed out of the facility and admitted that was not the truth.</p> <p>In an interview on 02/25/2025 at 11:25 AM, Staff F (Unit Manager) stated Resident 90 had the right to leave the facility and the facility had a sign in and sign out book they used to monitor residents. Staff F stated the physician order that showed Resident 90 needed to be accompanied out of the facility could have been incorrect and the facility should have had the order verified but did not.</p> <p>In an interview on 02/24/2025 at 01:48 PM Staff A (Administrator) stated the facility was aware that Resident 90 left the facility unaccompanied and stated Resident 90 told the facility they wanted to go alone and did not need an escort. Staff A stated they were not aware of the physician order showing Resident 90 needed to be accompanied and the doctor may have ordered that because Resident 90 had a Percutaneous Intravenous Central Catheter line (PICC, an inserted tube placed within a vein to deliver fluids and medication into the bloodstream) used to receive antibiotics for their infection. Staff A stated the CP should have been revised to show Resident 90 could leave the facility on their own but was not currently updated with this information.</p> <p>Refer to F552 - right to be informed</p> <p>Refer to F656 - develop/implement comprehensive care plan</p> <p>Refer to F658 - services provided meet professional standards</p> <p>REFERENCE: WAC 388-97-1060 (3)(g).</p>		

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NAME OF PROVIDER OR SUPPLIER  Benson Heights Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  22410 Benson Road SE Kent, WA 98031	
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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>50511</p> <p>Based on observation, interview, and record review the facility failed to ensure 2 of 5 sampled residents (Residents 38 &amp; 22) reviewed for Oxygen (O2) administration were provided care consistent with professional standards of practice. Failure to provide oxygen monitoring and maintain oxygen equipment left residents at risk for respiratory discomfort, oxygen-related accidents, infection, and a decreased quality of life.</p> <p>Findings included .</p> <p>&lt;Facility Policy&gt;</p> <p>According to the facility's July 2018, Quality of Care Respiratory Care Policy, the facility would assure respiratory care was provided to residents in need of such care. The care would be consistent with professional standards of practice, the comprehensive person-centered care plan and resident's goals. The facility would have procedures for response to adverse reactions to respiratory interventions, for respiratory assessments and should include when and how the assessment would be conducted and the type of documentation required.</p> <p>&lt;Providing Oxygen Level Monitoring&gt;</p> <p>&lt;Resident 38&gt;</p> <p>According to the 01/07/2025 Annual Minimum Data Set (MDS - an assessment tool) Resident 38 had respiratory failure with low blood (O2) levels.</p> <p>Review of the revised 07/22/2024 Respiratory Failure Care Plan (CP) showed staff were to monitor for signs and symptoms of respiratory distress and report these findings to the provider. The CP showed the symptoms staff were to report to the provider included increased respirations and decreased blood oxygen levels.</p> <p>Review of a physician order dated 05/31/2024 showed staff were to monitor Resident 38's blood O2 levels every shift and to notify the provider of low O2 levels when Resident 38 was using supplemental O2.</p> <p>Review of a February 2025 Treatment Administration Record (TAR) showed an order dated 02/05/2025 to provide O2 at a rate of 1 to 4 liters per minute every shift and to maintain O2 blood levels greater than 90%. The February TAR showed on 02/01/2025, 02/02/2025, 02/03/2025, 02/04/2025, 02/05/2025, 02/10/2025, 02/11/2025 and 02/15/2025 O2 blood levels were at 90% or lower.</p> <p>Review of progress notes in Resident 38's health record from 01/31/2025 through 02/18/2025 did not show documentation that the provider was notified of low O2 levels and did not show further documentation by the nurse practitioner regarding adjusting O2 level orders.</p> <p>Interview on 02/21/2025 at 8:44 AM, Staff O (Certified Nursing Assistant) stated Resident 38 was not as responsive today and was coughing.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 02/21/2025 at 11:35 AM showed Staff F (Unit Manager) inform care staff they were to get Resident 38 up from bed because people with respiratory illness need to be up in the wheel chair and Resident 38 also needed to be monitored.</p> <p>In an interview on 02/25/2025 at 11:12 AM Staff F stated low O2 levels should be documented in Resident 38's progress notes and the provider should have been notified.</p> <p>In an interview on 02/25/2025 at 2:19 PM Staff B (Director of Nursing) stated staff should have notified the provider of Resident 38's low O2 levels and should have documented this in the progress notes. Staff B stated this was important to notify the provider of Resident 38's care and to document providers orders if a change in plan of care was needed.</p> <p>47836</p> <p>&lt;O2 Equipment Maintenance&gt;</p> <p>&lt;Resident 22&gt;</p> <p>Review of a 07/19/2024 Annual MDS Resident 22 had respiratory failure, chronic obstructive pulmonary disease, and dependence on supplemental O2. The MDS showed Resident 22 received O2 during the assessment period.</p> <p>Review on 02/19/2025 of Resident 22's physician orders showed no order to change O2 tubing.</p> <p>Observation on 02/19/2025 at 9:38 AM showed Resident 22 with O2 being administered via nasal canula. Resident 22's nasal canula was dated 02/13/2025.</p> <p>Observation and interview on 02/21/2025 at 9:03 AM showed Resident 22's O2 tubing dated 02/13/2025. Staff F stated it was the facility's policy to change O2 tubing weekly. Staff F stated Resident 22's tubing was not changed according to facility policy but should have been. Staff F stated it was important to change O2 tubing weekly to prevent respiratory infections.</p> <p>REFERENCE: WAC 388-97-1060(3)(j)(vi).</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>50511</p> <p>Based on observation, interview, and record review the facility failed to ensure pain management was provided to residents consistent with professional standards of practice including the failure to follow parameters for administration of as needed (PRN) pain medications for 1 of 3 residents (Resident 74) reviewed for pain management and monitor for side effects to pain medications for 1 of 5 residents (Resident 22) reviewed for unnecessary medications. These failures placed residents at risk for experiencing untreated pain, possible side effects, and a decreased quality of life.</p> <p>Findings included</p> <p>&lt;Facility Policy&gt;</p> <p>According to the facility's 11/2017 Pain Management policy, the facility would conduct an evaluation of pain based on professional standards of practice. An evaluation included current medical conditions and medication and satisfaction with current level of pain control. The facility would implement both pharmacological and non-pharmacological interventions and approaches to pain management. The policy showed the facility would conduct ongoing clinical assessments and identify changes in condition. The policy showed the facility would monitor for appropriate effectiveness and/or adverse consequences such as sedation.</p> <p>&lt;Resident 74&gt;</p> <p>According to a 10/09/2024 Annual Minimum Daily Set (MDS-an assessment tool) Resident 74 had diagnoses of stroke impacting their spinal cord and chronic nerve pain. Resident 74 was taking pain medications for their condition.</p> <p>Review of a 08/13/2024 Pain Care Plan (CP) showed staff were to administer pain medications per orders and monitor the level of pain based on pain scale of 1 to 10 for Resident 74.</p> <p>Review of Resident 74's February Medication Administration Record (MAR) showed an order for a PRN pain medication to be administered at 5 Milligrams (mg) for a pain level 3-6/10 and 10 mg for a pain level of 7-10/10. The February MAR showed Resident 74 complained of a pain level less than 7/10 on 02/08/2025 and 02/19/2025 but staff administered the 10 mg pain medication and did not follow the ordered parameters. The February MAR showed Resident 74 complained of pain greater than 7/10 on 02/21/2025 and 02/23/2025 but staff only administered the 5 mg dose, not following the physician ordered pain medication parameters.</p> <p>In an interview on 02/19/2025 at 9:20 AM, Resident 74 stated sometimes after taking their pain medication they still had a pain level of 6/10 on the pain scale and did not think the pain medication was enough.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 02/25/2025 at 11:35 AM Staff E (Unit Manager) stated the medication nurse should be following the correct parameters for pain medications to help Resident 74 control their pain. Staff E stated their expectation would be that the nurses would follow the physician ordered pain medication parameters and reassess Resident 74 after administration for pain medication effectiveness and follow up with the physician if Resident 74 still had uncontrolled pain.</p> <p>In an interview on 02/25/2025 at 2:26 PM, Staff B (Director of Nursing) stated their expectation would be for staff to follow the physician ordered pain medication parameters for Resident 74. Staff B stated they expected staff to assess Resident 74's pain level after administration of pain medications and follow up with the physician for uncontrolled pain.</p> <p>47836</p> <p>&lt;Resident 22&gt;</p> <p>Review of a 07/19/2024 Annual MDS Resident 22 had no memory impairment. The MDS showed Resident 22 received a scheduled pain medication regimen during the assessment period. The MDS showed Resident 22 had diagnoses of, but not limited to, low back pain and arthritis.</p> <p>Review of Resident 22's health records showed a 04/15/2024 physician order for scheduled routine pain medication, a 04/22/2024 order for routine pain medication, and a 03/24/2024 order for PRN pain cream. Resident 22's health records did not show an order to monitor for side effects to these medications.</p> <p>In an interview on 02/18/2025 at 2:22 PM Resident 22 stated they had a hard time staying awake and feel like their medication was making them sedated but was unsure of which medication. Observations on 02/18/2025 at 2:22 PM, 02/19/2025 at 9:22 AM, 02/20/2025 at 1:26 PM, 02/21/2025 at 8:31 AM, and 02/24/2025 at 8:55 AM showed Resident 22 lethargic, able to follow conversation but falling asleep multiple times during each observation. Resident 22 kept apologizing stating they couldn't stay awake and were so sleepy all of the time.</p> <p>In an interview on 02/25/2025 at 8:45 AM Staff F (Unit Manager) stated Resident 22 did not have an order to monitor for side effects to pain medications but should. Staff F stated it was important to ensure Resident 22 was not having side effects to the pain medications and to monitor the medications effectiveness.</p> <p>REFERENCE: WAC 388-97-1060(1).</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p>42203</p> <p>Based on interview and record review the facility failed to ensure medically-related social services were provided for 2 of 2 residents (Residents 10 &amp; 21) reviewed for Pressure Ulcers (PU). The failure to provide assistance to residents demonstrating behaviors of rejection of care placed residents at risk for worsening skin and other negative health outcomes.</p> <p>Findings included .</p> <p>&lt;Policy&gt;</p> <p>According to the facility's 2018 Quality of Care - Skin Integrity policy, the facility would provide the necessary care to prevent the development of new PU. The policy showed certain risk factors for PU development could not be modified including resident refusals of care and treatment.</p> <p>&lt;Resident 10&gt;</p> <p>According to the 12/20/2024 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 10 had diagnoses including a condition hindering urinary flow, dementia, a mental health diagnosis, and muscle weakness. The MDS showed Resident 10 had a moderate memory impairment and refused care on one-to-three days of the MDS lookback period. The MDS showed Resident 10 had three full thickness tissue loss PUs, one with exposed bone, tendon, or muscle.</p> <p>Review of the 09/23/2024 Behaviors Related to residual mental health diagnosis Care Plan (CP) showed Resident 10 had behaviors including refusing medications and treatments. This CP included a goal for Resident 10 to have fewer behaviors. The CP included interventions staff should implement; provide Resident 10 positive interaction, discuss the resident's behavior, monitor the behavior, and attempt to determine the underlying reason for the behavior. The CP showed both nurses and social workers were responsible for implementation of these interventions.</p> <p>Review of the behavior monitoring showed nurses documented Resident 10 refused care (turning and repositioning) on 5 occasions between 02/10/2025 and 02/22/2025.</p> <p>Review of the resident's weight records showed on 12/28/2024, Resident 10 weighed 136.5 lbs. On 01/20/2025, Resident 10 weighed 126 pounds which represented a 7.69 % loss.</p> <p>According to the 01/29/2025 skin and nutrition review showed Resident 10 refused some of their meals.</p> <p>In an interview on 02/25/2025 at 9:55 AM, Staff B (Director of Nursing) stated Resident 10's poor dietary intake including refusals of dietary supplements and refusals to be turned contributed to Resident 10's skin impairments. Staff B stated Resident 10's wounds and weight loss were not preventable.</p> <p>&lt;Resident 21&gt;</p> <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>According to the 12/19/2024 Quarterly MDS Resident 21 had moderate memory impairment and refused care on one-to-three days of the MDS lookback period. The MDS showed Resident 21 had diagnoses including dementia, malnutrition, depression, difficulty swallowing, and the presence of full thickness tissue loss PUs. The MDS showed Resident 21 had two full thickness tissue loss PUs and required an altered texture diet.</p> <p>According to the 09/05/2024 resident is resistive to care [and] to reposition[ing] in bed . CP, Resident 21's goal was to be cooperative with care. The CP showed staff should encourage as much participation in care as Resident 21 would allow. This CP did not identify social workers among the staff responsible to encourage Resident 21 to participate in care.</p> <p>In an interview on 02/25/2025 at 10:09 AM Staff B stated Resident 21's wounds were not preventable. Staff B stated Resident 21's diminished dietary intake and refusals of repositioning made wound prevention and healing difficult.</p> <p>In an in interview on 02/25/2025 at 1:43 PM Staff D (Social Services Director) stated the role the social services held regarding refusals of care was to determine the root cause of the behavior and see what might help them accept the care, and failing that, educating facility staff on residents' rights to refuse care and how to manage those refusals. Staff D stated they learned of patterns of refusals from the nursing department. Staff D stated they were unaware of Resident 10's refusals of care. Staff D stated they were aware that Resident 21 had a behavior of persistently crying out for help but did not know they refused care.</p> <p>REFERENCE: WAC 399-97-0960 (1).</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>47836</p> <p>Based on record review and interview, the facility failed to ensure freedom from unnecessary medications for 1 of 2 residents (Resident 63) reviewed for antibiotic use. The failure to ensure an order for antibiotic therapy was transcribed accurately per physician order resulted in Resident 63 receiving an unnecessary medication for an excessive duration and placed them at risk of experiencing avoidable adverse side effects to the medication and other potential negative health outcomes.</p> <p>Findings included .</p> <p>&lt;Resident 63&gt;</p> <p>According to a 01/10/2025 Admission Minimum Data Set (MDS - an assessment tool) Resident 63 had no memory impairment. The MDS showed Resident 63 required use of a continuous positive airway pressure (non-invasive mechanical ventilator or respirator) machine while sleeping.</p> <p>In an interview on 02/18/2025 at 9:59 AM Resident 63 stated they took an antibiotic for a sinus infection.</p> <p>Review of Resident 63's health records showed a 01/15/2025 physician order for an antibiotic for a sinus infection. The antibiotic order was to be a 14-day course. Resident 63's medication administration records showed they started the antibiotic on 01/15/2025 and received the last dose on 02/07/2025, nine days longer than the physician ordered 14-day course.</p> <p>In an interview on 02/24/2025 at 11:49 AM Staff C (Infection Preventionist) stated Resident 63 should have received the antibiotic for 14 days and not for 23 days.</p> <p>In an interview on 02/24/2025 at 1:59 PM Staff E (Unit Manager) stated they revised the antibiotic order on 01/24/2025 and left the 14-day administration period in the body of the order causing the order to restart the 14-day administration course over again on 01/24/2025. This meant staff administered the antibiotic for a total of 23 days. Staff E stated it was a medication error and Resident 63 should have received the antibiotic for a total of 14 days like the physician ordered and not 23 days.</p> <p>REFERENCE: WAC 388-97-1060 (3)(k)(i).</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>42203</p> <p>Based on observation, interview, and record review the facility failed to ensure residents requiring specialized diets were provided the diets required for 1 of 4 residents (Resident 64) reviewed for food. The failure to provide specialized diets residents were assessed to require placed residents at risk for unmet nutritional needs and other negative health outcomes.</p> <p>Findings included .</p> <p>&lt;Facility Policy&gt;</p> <p>According to the facility's 07/2018 Food and Nutrition Services policy, the facility would provide for the nutritional wellbeing of all residents. The policy showed the facility would provide residents with a nourishing, palatable, and well balanced diet to meet daily nutritional and special dietary needs.</p> <p>&lt;Resident 64&gt;</p> <p>According to 12/14/2024 Quarterly Minimum Data Set, Resident 64 had intact memory and required a specialized (therapeutic) diet. The MDS showed Resident 64 had medically complex diagnoses including stage-2 kidney disease, diabetes mellitus (a condition impairing the ability to manage blood glucose), and morbid obesity. The MDS showed Resident 64 required an altered texture, therapeutic diet.</p> <p>Record review showed Resident 64's kidney condition was downgraded from stage-2 kidney disease to a new diagnosis of stage-3 kidney disease on 02/17/2025.</p> <p>Recorded review showed a 02/18/2025 dietary order indicating Resident 64 required carbohydrate-controlled, renal (kidney) diet.</p> <p>In an interview on 02/18/2025 at 10:18 AM Resident 64 stated they did not like the food provided by the facility.</p> <p>In an interview on 02/20/2025 at 11:46 AM breakfast Resident 64 stated they were concerned the facility did not provide a menu to meet their nutritional needs. As an example, Resident 64 stated the breakfast provided that day included four pieces of toast which was too many carbohydrates for them.</p> <p>&lt;Facility Kitchen&gt;</p> <p>On 02/18/2025 at 8:53 AM the Staff S (Dining Services Director) provided the break-out menus, a spreadsheet indicating what if any modifications were required from the standard menu for residents with dietary orders. Review of this document showed Staff S only provided the altered texture menus, not the therapeutic diets.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During lunch preparation on 02/21/2025 at 9:46 AM, the outstanding menu information was requested of Staff S. Staff S stated they did not know where the menus were. Staff S stated normally that information was printed out and kept on a clipboard near the steam table but was not where they expected at that time and was not there since the day prior. Staff S stated they would print out and provide the therapeutic diet menus. Staff S then sat at their desk and began looking for the break-out menus to print.</p> <p>On 02/21/2025 at 9:56 AM Staff S was asked how dietary staff would know what to prepare for a resident requiring a renal diet. Staff S stated there were no residents requiring a renal diet in the facility at that time. Staff S then reviewed Resident 64's order and stated they were unaware of the order for a renal diet.</p> <p>On 02/21/2025 at 10:04 AM Staff S was still working on their computer, trying to figure out how to access and print the break-out menu. At that time, Staff S stated in the absence of menus they wrote out the numbers of each diet type (controlled-carbohydrate, low sodium etc.) so dietary staff would know what to prepare. Review of these instructions left for staff for the evening of 02/20/2025 showed this list did not explain the composition of the meal trays staff should provide for the different menus listed. This list showed to prepare 46 regular meals, 16 carbohydrate-controlled meals, 13 no-salt meals, four vegetarian meals, and 1 full-liquid meal. No renal diet meal was listed.</p> <p>On 02/21/2025 at 10:12 AM Staff S called out to a third-party to seek assistance on how to access and print out the break-out menus. Staff S remained on the phone through 10:24 AM. At 10:30 AM Staff S located the menu open on their desktop and left to print a copy. In total, Staff S took 44 minutes to access and provide the break-out menu. The break out menu showed for some therapeutic diets, sweetened, whipped carrots should be substituted with sliced carrots. At 11:49 AM the steam table was observed to have no sliced carrots available.</p> <p>In an interview on 02/25/2025 at 8:55 AM, Staff S stated the dietary staff should follow, but did not follow the break-out menu in order to ensure residents received the nutrition they required.</p> <p>In an interview on 02/25/2025 at 12:37 PM Staff T (Dietician) stated it was important for residents to receive the diet they were assessed to require. Staff T stated dietary staff should have followed the break-out menus.</p> <p>REFERENCE WAC 388-97-1160 (1)(a)(b).</p>		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>42203</p> <p>Based on observation, interview, and record review the facility failed to ensure food and drinks served to residents were prepared and distributed under sanitary conditions for 1 of 1 facility kitchens. The failure to maintain an effective system for sanitizing counters and monitor refrigerator temperatures placed residents at risk for contaminated/spoiled food, foodborne illness, and other negative health outcomes.</p> <p>Findings included .</p> <p>&lt;Facility Policy&gt;</p> <p>According to the facility's 07/2018 Food and Nutrition Services - Food and Drink policy, the facility would be provided food and drink prepared using methods to preserve the nutritive value, flavor, and appearance of the food.</p> <p>&lt;Facility Kitchen&gt;</p> <p>During initial rounds of the facility kitchen on 02/18/2025 from 8:54 AM to 9:08 AM no log documenting facility staff monitored the kitchen's sanitizing solution was at an effective concentration was found. Staff S (Dining Services Director) asked the kitchen staff if anyone knew where the log was, and no staff could provide an answer. At that time Staff S stated the daytime dietary staff started their shift at 6 AM and therefore the sanitizer was not checked for being at an effective concentration since shift change over three hours prior.</p> <p>Review of the refrigerator logs on 02/18/2025 at 9:03 AM showed no temperatures were logged for the kitchen refrigerators since 02/15/2025, meaning the temperature of the refrigerators were not checked on 02/16/2025 and 02/17/2025. Staff S stated they expected the logs to be maintained daily but they were not.</p> <p>During observations of lunch preparations on 02/21/2025 Staff S stated they were no paper towels. Observation at that time showed the paper towel dispenser was empty. On the nearest counter to the left, a roll of paper towels was placed where the loose part of the paper towel roll was resting against a can opener. The top of the paper towel roll was dotted with drips of water from staff using the roll from the counter to wash their hands. At that time with gloved hands, Staff U (Dietary Aide) took a large piece of paper towel from the roll on the counter and wiped down a cart. Staff U did not use any sanitizer or wash their hands before or after wiping the cart with paper towels and returned to food preparation.</p> <p>In an interview on 02/25/2025 at 8:55 AM, Staff S stated the paper towel dispenser should have been refilled when emptied instead of dietary staff placing it on the counter. Staff S stated they expected staff to check the sanitizer concentration as scheduled and only use sanitizer solution to clean surfaces. Staff S stated dietary staff should only use gloves when handling ready-to-eat foods.</p> <p>REFERENCE: WAC 388-97-1100 (3).</p>		