STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505519	A. Building B. Wing	05/06/2026

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

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F 0688 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide appropriate treatment, services and interventions to prevent an avoidable reduction of Range of Motion (ROM) for 1 of 5 sampled residents (Resident 4) reviewed for limited ROM. Resident 4 experienced harm as evidenced by after discharge from specialized rehab services the resident was able to open/close their right hand and perform Active ROM (AROM) and now Resident 4's right hand developed a contracture due not implementing therapy gloves, staff not consistently assisting resident with AROM as assessed and care planned. Resident 4 was also at risk for decreased ROM/worsening of left-hand contracture due to staff not implementing rehab training gloves, consistently applying splint, and consistently assisting the resident with Passive ROM (PROM). The failure to not provide appropriate services/interventions for ROM placed other residents at risk of developing new contractures and/or worsening of existing contractures.Findings included. <Facility Policy>Review of the facility policy titled, Restorative Nursing Programs (RNP), dated 11/2017, documented the facility would provide services, care, and equipment to assure residents maintained and/or improved their ROM. The policy showed RNP's would be developed and/or formulized by a supervising nurse and be included in the patients Care Plan (CP), The policy showed the RNP could include splint or brace assistance, and passive and/or active ROM.<Resident 4>According to a 02/23/2026 Quarterly Minimum Data Set (MDS- an assessment tool) assessment, Resident 4 readmitted to the facility on [DATE]. The MDS showed Resident 4 had no memory impairment. The MDS showed Resident 4 was able to make themselves understood and understood others. The MDS showed Resident 4 had a PROM and an AROM RNP. The MDS showed no splint or brace assistance was provided to Resident 4 during the assessment period. The MDS showed Resident 4 had diagnoses of paralysis of left side of the body and paralysis of the lower half of the body both legs, and a neurological disorder that affected movement, balance, and posture.Review of an active at risk for pain CP initiated on 08/26/2024 showed an intervention for staff to perform both upper and lower ROM/stretching for Resident 4.Review of a 05/03/2025 left upper extremity splint CP showed Resident 4 was to wear a splint to their left hand at all times. Resident 4's CP did not include a brace/splint to their right-hand contracture.Review of Resident 4's 07/22/2025 functional maintenance plan/RNP showed that staff were instructed to provide PROM to left hand, arm, shoulder, and AROM to right hand, arm and shoulder daily.Review of Resident 4's 07/31/2025 Activities of Daily Living (ADL) CP showed an intervention for a functional maintenance program that instructed staff to provide PROM of left hand, arm, shoulder, and AROM to right hand, arm, and shoulder.Review of Resident 4's behaviors related to loss of ADLs CP showed Resident 4 appreciated staff to do ROM/stretching exercises to alleviate their distress.Review of Resident 4's limited physical mobility CP showed a 02/27/2026 intervention for staff to provide AROM of right hand, arm, shoulder, and PROM of left hand, arm, and shoulder.In an observation and interview on 04/29/2026 at 1:52 PM Resident 4 stated they were concerned about their hands being stuck closed. Observation showed Resident 4's bilateral hands were contracted closed, and Resident 4 was unable to open either hand. Resident 4 stated staff did not assist them (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0688 Level of Harm - Actual harm Residents Affected - Few	with ROM services. Resident 4 stated the guy from therapy instructed staff on how to use rehab training gloves for both hands but staff did not provide the treatment since instruction. A box with rehab trainings gloves with the gloves in it was on Resident 4's nightstand. Resident 4 stated the gloves had sat on their nightstand since last year when therapy placed them there, but staff had not assisted them with using the gloves. Resident 4 stated they really wanted to use the rehab training gloves to keep their ROM to both hands and had expressed this to many unidentified staff but still did not receive the rehab training gloves treatment.Observations and interviews on 04/30/2026 at 10:17 AM, 05/01/2026 at 8:14 AM, and 05/04/2026 at 10:55 AM showed Resident 4 with bilaterally contracted hands and no splint. Resident 4 stated staff did not offer or provide rehab training gloves, splint, or any ROM services on any of these days.In an observation and interview on 05/04/2026 at 12:04 PM Resident 4 was up in their wheelchair in the day room with both hands contracted and resting in lap without a splint on either contracted hand. Staff O (Certified Nursing Assistant - CNA) stated Resident 4 was supposed to have a splint to their left hand per CNA tasks. Staff O searched Resident 4's room and stated they did not have a splint in their room, but a palm protector was in their drawer. Staff O stated they should have applied a splint to Resident 4's left hand in the AM to wear during the day, but they did not. Staff O stated they were also supposed to sometimes assist with ROM to resident 4's hands. Staff O stated the splint and ROM treatments were important to prevent decreased ROM.Observation and interview on 05/05/2026 at 9:27 AM showed Resident 4 wearing a splint to their left-hand contracture but no splint to their right hand. Resident 4 stated staff still did not offer or provide the rehab training gloves.Interview on 05/05/2026 at 9:38 AM Staff F (Unit Manager) stated they expected staff to ensure Resident 4 always wore the splint to their left hand per CP and offer and provide ROM services to both hands daily. Staff F stated it was important to provide splint and ROM treatments to prevent decrease in ROM. Staff F reviewed Resident 4's ADL self-care deficit CP and stated staff were expected to offer and provide PROM to Resident 4's left hand, arm, shoulder, and AROM to their right hand, arm, and shoulder. Staff F stated they were notified last year sometime about Resident 4's rehab training gloves and was instructed by Staff K (Therapy Coordinator) that Resident 4 needed to use them daily for a certain number of minutes. Staff F stated Staff K had instructed the CNAs that worked with Resident 4 routinely on how to use them and about the addition of the rehab training gloves to Resident 4's RNP. Staff F stated they forgot to add the rehab training gloves to Resident 4's CP or physician orders but should have. Staff F stated it was important to add the rehab training gloves to Resident 4's CP so staff would offer and provide the rehab training gloves per therapy recommendations. Staff F stated the rehab training gloves were important to assist in prevention of decreased ROM.In an interview on 05/05/2026 at 9:49 AM Staff K stated when Resident 4 discharged from specialized rehab services they instructed staff how to use the rehab training gloves and to provide them to Resident 4 daily. Staff K stated they wrote a Functional Maintenance Program/RNP which included the rehab training gloves to be offered and provided daily. Staff K stated the gloves were an important part of Resident 4's ROM services to prevent a decrease in ROM to both of their hands.In record review and interview on 05/05/2026 at 11:03 AM staff K provided a copy of the Occupational Therapy (OT) discharge plan created by Staff P (OT) on 11/17/2025 which showed Resident 4 was able to tolerate the rehab training gloves to both hands to perform table top tasks for 20 minutes and all Resident 4's caregivers were trained on and to continue the rehab training gloves twice daily for 20 minutes and that a Functional Maintenance Plan/RNP was not indicated for Resident 4 at that time. Staff K assessed Resident 4's contractures and stated they were worse than when Resident 4 discharged from therapy to the RNP. Staff K asked Resident 4 to open their right hand and Resident 4 attempted but was unable to move their right hand at all. Staff K stated Resident 4 was able to fully open and close right hand on their own when they discharged from specialized rehab services and transitioned to the RNP but now was unable. Staff K attempted to perform PROM to both hands and stated they would get a splint for Resident 4's right hand, apply warm packs for ROM, and would get Resident 4 back on specialized rehab (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	services.Review of a 05/05/2026 revision to Resident 4's CP showed staff would apply a splint to Resident 4's right hand.Observation and interview on 05/06/2026 at 8:13 AM showed Resident 4 in bed without a splint to either hand. Resident 4 stated staff still did not offer or provide the rehab training gloves and only put the splints to both hands on 05/05/2026.In an interview on 05/06/2026 at 8:28 AM Staff N (CNA) stated they worked with Resident 4 yesterday but did not do PROM or AROM with the resident because they were wearing splints to both of their hands. Staff N stated they had signed the CNA task to perform ROM services to bilateral hands as if they had assisted Resident 4 with the treatments because they thought the splints did that since they stretched the residents' hands out and did not understand what it meant to offer/provide PROM/AROM treatments. Staff N stated they remembered being trained last year on the rehab training gloves by Staff K but had not seen them listed on Resident 4's CNA tasks to provide since the training occurred. Staff N stated Resident 4 could not perform AROM to their right hand because Resident 4 was now unable to move either hand on their own. Staff N stated it was important to provide splints and ROM treatments to prevent decreased ROM.In an interview on 05/06/2026 at 9:15 AM with Staff A (Administrator) and Staff B (Director of Nursing) stated they expected staff to follow CPs, offer and provide ROM treatments, and apply splints for contractures. Staff B stated they expected staff to add the rehab training gloves to Resident 4's Functional Maintenance Program/RNP, obtain a physician order and add the gloves to Resident 4's CP but they did not. Staff B stated it was important to prevent decreased ROM.Reference WAC 388-97-1060 (3)(d).

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interview and record review, the facility failed to ensure Staff H (Dining Services Manager) met the minimum qualifications to serve as the director of food and nutrition services when the facility had no qualified dietitian or other clinically qualified nutrition professional employed full-time. This failure placed residents at risk for unmet nutritional needs and for receiving unsafe dietary services from staff without the required competencies and skills to carry out food and nutrition services management.Findings included. <Facility Policy>According to the facility's Food and Nutrition Services Qualified Dietary Staff policy, dated July 2018, if a dietician or qualified nutrition professional was not employed full-time, the facility would designate a director of food and nutrition services who was a Certified Dietary Manager (CDM), or a certified food service manager, or have similar national certification of food service management and safety, or had an associates or higher degree in food service management or hospitality. In an interview on 04/29/2026 at 8:27 AM, Staff H stated they had served as the facility's dietary manager since September 2025.Review of a staff list provided on 05/01/2026 showed the facility hired Staff H on 08/21/2025.In an interview on 05/04/2026 at 8:38 AM, Staff H stated they were working to complete an on-line course to obtain their CDM credential and were hoping to complete it in June 2026 or July 2026. Staff H stated they started the course in March 2026 and had until the beginning of 2027 to complete it. Staff H stated the facility had a Registered Dietician (RD) that came to the facility once a month to see residents and held weekly meetings with Staff H and the nursing unit managers to discuss resident-specific nutritional concerns.In an interview on 05/05/2026 at 2:45 PM, Staff I (RD) stated they routinely came to the facility once a month to see residents and to do a walk-through in the kitchen, and they had weekly virtual meetings with unit managers. Staff I stated they were not aware that Staff H did not meet the minimum qualifications to serve as the dietary manager.Review of a 01/08/2026 e-mail correspondence showed Staff H enrolled in a Dietary Manager Training course that started on 01/14/2026 and was scheduled to end on 01/14/2027.In an interview on 05/05/2026 at 1:24 PM, Staff A (Administrator) reviewed Staff H's employee file and stated Staff H was taking a course to obtain their CDM, and they currently did not meet the federal criteria to work as the dietary manager. Staff A stated Staff H had over two years of experience working as a dietary manager at an assisted living facility but did not meet the federal requirement to complete a course of study in food safety and management by no later than 10/01/2023. Staff A stated that they thought dietary managers had a certain amount of time allowed to work on obtaining a CDM, but they were mistaken. No documentation was provided regarding Staff H's qualifications to serve as a dietary manager.Refer to F803- Menus Meet Resident Needs/Prep in Advance/Followed.Refer to F812- Food Procurement, Store/Prepare/Serve - Sanitary.Reference WAC 388-97-1160 (1)(2)(3)(a)(b)(i)(ii).

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. Based on observation, interview and record review, the facility failed to ensure the menu was followed for 1 of 1 sample residents (Resident 15) reviewed for food concerns, and failed to implement a system to ensure residents were provided with the correct food portion sizes according to their assessed nutritional needs for 1 of 1 kitchen tray line observations. These failures placed residents at risk for unmet nutritional needs and a diminished quality of life.Findings included. <Facility Policy>According to the July 2018 facility's Food and Nutrition Services Menus and Therapeutic Diets policy, the facility would have and follow menus that met the nutritional and personal needs of the residents. <Menu Items><Resident 15>According to the 02/24/2026 annual Minimum Data Set (MDS - an assessment tool), Resident 15 was usually able to understand and to be understood, had no natural teeth, and was on a mechanically altered diet.In an interview on 04/29/2026 at 1:25 PM, Resident 15 stated they were on a pureed (blended, whipped, or mashed into a smooth consistency, requiring no chewing) diet because they did not have any teeth. Resident 15 stated they were served mashed potatoes for every lunch and dinner, they were tired of it, and they felt it was too much starch for their nutritional needs.In an interview on 05/04/2026 at 8:54 AM, Staff H (Dining Services Manager) stated residents on a pureed diet received the same menu items as other residents. If the menu item was pasta, residents on a pureed diet would receive pureed pasta.Review of a Spring/Summer 2026 - Week 4 menu showed the lunch menu for 05/04/2026, included chicken alfredo with noodles and cauliflower.In an observation of the kitchen tray line on 05/04/2026 at 11:34 AM, Staff J (Cook) prepared a lunch plate for Resident 15 that included mashed potatoes with sauce, pureed chicken, and pureed cauliflower. Similar findings were observed with lunch plates for other residents on pureed diets. Residents with regular texture diets received noodles and chicken with sauce and cauliflower.In an interview on 05/04/2026 at 12:53 PM, Staff J stated they served mashed potatoes for lunch for residents on pureed diets. Staff J stated they were able to puree noodles as indicated on the menu, but they did not.In an interview on 05/05/2026 at 2:45 PM, Staff I (Registered Dietician - Regional) stated residents on a pureed diet should receive the same menu items as other residents. Staff I stated they were concerned that residents' nutritional requirements may not be met if staff did not follow the menu.<Kitchen Tray Line Observation>In an interview on 05/04/2026 at 8:54 AM, Staff H stated they received their menus through a food supplier, and a corporate Registered Dietician adjusted the menus to meet the needs of the facility. Staff H stated they did not have access to a break-out menu (a spreadsheet showing portion sizes for each menu item according to the various prescribed diets), and staff used each resident's tray card to determine the portion size to serve them. Staff H stated they reviewed the correct portion-size scoops to use with staff before serving each meal.Review of a Spring/Summer 2026 - Week 4 menu showed the lunch menu and portion sizes for 05/04/2026, included two #8 scoops of chicken alfredo with noodles and 1/2 cup cauliflower. The menu did not break down the portion size for chicken, noodles, or alfredo sauce.Review of an undated Portion Control Scoops Color Guide included the following scoops:#8 Gray, 1/2 cup#12 Green, 1/3 cup#16 Blue, 1/4 cup#20 Yellow, 1/5 cup#30 Black, 2 tbsp.Observations on 05/04/2026 from 11:17 AM to 11:31 AM showed Staff J prepared to begin lunch service. Staff J chose colored scoops from a bin and placed a scoop in each food container on the tray line. At that time, Staff H was in their office and was not observed participating in scoop selection.Observation on 05/04/2026 at 11:34 AM showed Staff J prepared Resident 15's lunch plate. The tray card showed no portion size for the entree, and 1/2 cup of cauliflower. Staff J used a green scoop (1/3 cup) for mashed potatoes, a yellow scoop (1/5 cup) for pureed chicken, and a yellow scoop (1/5 cup) for pureed cauliflower. Staff J stated they used yellow scoops for the pureed foods at every meal.Observation on 05/04/2026 at 11:57 AM showed Staff J prepared a lunch plate for a resident whose tray card indicated a minced and moist diet (consists of soft, finely minced, or ground foods (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	that are moist and easy to swallow). Staff J used a green scoop (1/3 cup) for mashed potatoes, a yellow scoop (1/5 cup) for minced chicken, and a blue scoop (1/4 cup) for minced cauliflower.Observations on 05/04/2026 from 11:35 AM to 12:51 PM showed Staff J prepared lunch plates for residents on regular texture diets using a large black scoop (not listed on the scoop color guide) for noodles, a green scoop (1/3 cup) for chicken, a blue scoop (1/4) cup for sauce, and a gray scoop (1/2 cup) for cauliflower. Staff J frequently used heaping scoops and/or added extra partial scoops of food to the plates. For residents whose tray card indicated large portions or double portions, Staff J used two scoops of each item and frequently added extra amounts.In an interview on 05/04/2026 at 12:53 PM, Staff J was asked how they determined which scoops to use for each food item. Staff J stated they used the scoops they usually used and sometimes added a little more food on the plates.In an interview on 05/04/2026 at 12:55 PM, Staff H stated that residents on altered texture diets should get the same size portions as residents on regular texture diets. Staff H stated it was a problem that the menu did not break down the portion sizes for the chicken, noodles, and alfredo sauce.In an interview on 05/05/2026 at 2:45 PM, Staff I stated Staff H should have access to a more detailed break-out menu through their computer application that showed portion sizes for each food item according to each diet type. Staff I stated staff should use the appropriate scoop sizes according to the break-out menu. Staff I stated residents on pureed diet should receive the same portion sizes as residents on regular diets.REFERENCE: WAC 388-97-1100 (1).

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 food was stored and prepared under sanitary conditions for 1 of 1 kitchens and 1 of 1 unit refrigerators designated for resident use. The failure to ensure food was not expired, ensure proper food labeling, and ensure staff performed hand hygiene during food preparation placed residents at risk for foodborne illness and the spread of infection.Findings included. <Facility Policy>According to the facility's July 2018 Food and Nutrition Services Food Safety policy, food items would be stored, prepared, distributed and served in accordance with professional standards for food service safety. Food in the refrigerator would be labeled and dated. Staff would practice good hygienic practices and techniques. <Food Storage><Kitchen>Observation with Staff H (Dining Services Manager) on 04/29/2026 at 8:27 AM showed the following items found in kitchen storage areas and kitchen refrigerators:Large plastic bag of sliced pepperoni with a handwritten date of 09/02/2025, eight months prior, and no other labeling.Three crates of eggs with no labeling, no expiration date.In an interview on 04/29/2026 at 8:27 AM, Staff H stated they pulled the pepperoni from the freezer the previous night. Staff H stated they should label the bag to show when it was refrigerated, but did not.In an interview on 05/04/2026 at 8:51 AM, Staff H stated they got the eggs from their food supplier about two weeks ago. Staff H stated the egg crates came from the supplier in a labeled box and staff took them out of the box.Observation on 05/04/2026 at 8:52 AM showed a kitchen refrigerator contained 3 undated containers of individually wrapped sandwiches.In an interview on 05/04/2026 at 8:56 AM, Staff T (Dietary Aide) stated they were busy with the tray line and forgot to date the sandwiches. STaff T stated they should date the sandwiches.<Unit Refrigerator>Observation with Staff S (Behavioral Tech) on 05/04/2026 at 2:31 PM showed a unit refrigerator located outdoors on the resident's porch that contained the following:A plastic bag containing grapes, expiration date 04/15/2026.A plastic bag containing grapes, expiration date 04/24/2026.A plastic bag containing sliced meat with no open date or expiration date.A plastic container of sliced roast beef, expiration date 05/02/2026.In an interview on 05/04/2026 at 2:31 PM, Staff S stated the listed food items were expired or unlabeled and should have been discarded, but were not.In an interview on 05/05/2026 at 2:45 AM, Staff I (Registered Dietician - Regional) stated they had concerns about food storage practices at the facility. Staff I stated it was not acceptable to still store pepperoni dated 09/02/2025, eggs should have labeling to show where they came from and an expiration date, each sandwich should be labeled with a use by date, and food storage areas should be checked regularly for expired foods, but they did not.<Hand Hygiene (HH)>Observation on 05/04/2026 at 9:27 AM showed Staff J (Cook) used gloved hands to separate thawed chicken filets and place them on a baking tray. Staff J used a brush to apply sauce to the chicken filets. With the same gloved hands, Staff J opened the oven door, placed the tray in the oven, and adjusted the oven temperature dial. Staff J removed their gloves and did not perform HH. Staff J used a cloth to wipe off the countertops, opened the outside door and brought a garbage bag outside. Staff J returned to the kitchen, rinsed their hands for less than five seconds without using soap, and turned off the faucets without using a barrier. With bare hands, Staff J used a pitcher to add sauce to a pot of boiling water on the stove, added pasta from a bag to the pot, and used a ladle to stir the pot.Observations on 05/04/2026 at 9:43 AM, 05/04/2026 at 9:47 AM, 05/04/2026 at 9:51 AM, and 05/04/2026 at 11:21 AM showed Staff J went outside of the kitchen, came back to the kitchen, washed their hands for less than five seconds without using soap, turned off the faucets without using a barrier, and resumed food preparation activities. Observation on 05/04/2026 at 11:23 AM showed Staff V (Dietary Aide) washed their hands with soap and water, then turned off the faucets without using a barrier. Staff V then assisted Staff J to prepare trays for meal service.In an interview on 05/04/2026 at 1:06 PM, Staff H stated they expected kitchen staff to perform HH every time they changed gloves, touched something dirty, went outside the kitchen, smoked, or used the (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	bathroom. Staff H stated HH included using warm water and soap, washing for 20 seconds, rinsing, drying with a paper towel, then using a paper towel to turn off faucets.In an interview on 05/05/2026 at 2:45 PM, Staff I stated staff should perform HH every time they put gloves on, and every time they are touching something different to prevent cross-contamination. HH included washing hands with soap and warm water, scrubbing for 20 seconds including between fingers, rinsing, drying hands with a paper towel and using a paper towel to turn off faucets.Reference WAC 388-97-1100(3).

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure residents were provided with a homelike environment for resident areas in 2 of 3 units (North & Middle hallways) and the main dining room. These failures put residents at risk for skin injuries and a less-than-homelike environment. Findings included . <Facility Policy>The facility's 07/2018 Safe, Clean, and Comfortable Environment Policy showed residents would be provided a safe, clean, comfortable, and homelike environment. The policy showed the facility environment should be clean and sanitary. <Resident Areas>Observation on 04/29/2026 at 9:33 AM showed room [ROOM NUMBER]'s door panel/kick plate was broken with sharp edges, putting residents at risk for skin injuries. Observation showed room [ROOM NUMBER]'s door frame had dents and areas of paint were scratched off. Observation on 04/29/2026 at 10:55 AM showed room [ROOM NUMBER]'s door panel/kick plate was broken and the door frame had dents.Observation on 04/29/2026 at 11:05 AM showed room [ROOM NUMBER]'s door panel/kick plate was broken and the door frame had dents and paint chipped off. Observation on 04/29/2026 at 11:27 AM showed the North hallway wall base board was broken.Observation on 04/29/2026 at 11:42 AM showed room [ROOM NUMBER]-Bed 2 had a broken overhead bed light cover. The resident in room [ROOM NUMBER]-Bed 2 stated their overhead bed light cover had been broken for a while.Observation on 04/30/2026 at 8:47 AM showed residents in room [ROOM NUMBER] - Bed 1 and Bed 2 both had televisions (TVs) and were watching the same TV program. Both residents stated they could not watch the programs they each wanted to because both TVs played the same channels.In an observation and interview on 05/06/2026 at 9:23 AM, Staff R (Maintenance Director) confirmed the door panels/kick plates and door frames for rooms [ROOM NUMBER] and the baseboard in the North hallway were damaged and should be repaired. Staff R confirmed the overhead bed light cover in room [ROOM NUMBER] - Bed 2 was broken and should be fixed, and stated floor staff should have notified them of the broken light cover but did not. Staff R stated they should change room [ROOM NUMBER] - Bed 2's TV because both residents in room [ROOM NUMBER] had the same brand of TV, causing them to play the same programs at the same time.<Main Dining Room>Observation and interview on 05/06/2026 at 9:52 AM showed the main dining room in the South hallway by the kitchen had multiple floor tiles broken. Staff R confirmed the broken floor tiles and stated they needed to be fixed.In an interview on 05/06/2026 at 10:15 AM, Staff A (Administrator) stated their expectation was for residents to have a home-like environment. Staff A stated the door panels/kick plates, door frames, base boards, overhead bed light and floor tiles should be fixed and should be free from risk of injuries. Reference: WAC 388-97-0880.

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	505519	A. Building B. Wing	05/06/2026

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a copy of a written discharge or transfer notice to the Office of the State Long-Term Care Ombudsman (LTCO - resident advocates) for 1 of 3 residents (Resident 89) reviewed for closed records and 2 of 2 supplemental residents (Residents 24 & 95) reviewed for discharge notifications. Failure to notify the LTCO of all resident discharges placed residents at risk of a lack of advocacy in the event of an inappropriate discharge.Findings included. <Facility Policy>According to the facility's Admission, Transfer and Discharge - Transfer and Discharge Process policy, dated 04/28/2025, the facility would provide written notification to a resident and their representative before a transfer or discharge. Notifications to the LTCO would occur before or as close as possible to the actual time of transfer or discharge. The medical record would contain evidence of the notification sent to the LTCO. <Resident 89>Review of a Social Services Note, dated 03/02/2026, showed Resident 89 and their family member requested that Resident 89 be discharged home.Review of an IDT (Inter-Disciplinary Team) Discharge Planning and Summary, dated 03/02/2026, showed the facility discharged Resident 89 to their home in a family-directed discharge on [DATE]Review of Resident 89's Electronic Health Record (EHR) showed no evidence that a copy of a written discharge notice was provided to the LTCO.In an interview on 05/06/2026 at 8:17 AM, Staff D (Social Service Director) stated they did not notify the LTCO of Resident 89's discharge because Resident 89 and their family initiated the discharge. Staff D stated that they sent a list to the LTCO every month of residents who had facility-initiated discharges or transfers but did not inform the LTCO of residents who had resident-initiated discharges.<Resident 24>Review of an IDT Discharge Planning and Summary, dated 04/23/2026, showed the facility discharged Resident 24 to an adult family home in the community in a resident-driven discharge.Review of Resident 24's Electronic Health Record (EHR) showed no evidence that a copy of a written discharge notice was provided to the LTCO.<Resident 95>Review of a progress note, dated 03/06/2026, showed the facility discharged Resident 95 to an adult family home in the community.Review of Resident 95's EHR showed no evidence that a copy of a written discharge notice was provided to the LTCO.In an interview on 05/06/2026 at 9:24 AM, Staff D stated they did not notify the LTCO of Resident 24's or 95's discharges.Reference: WAC 388-97-0120 (2)(5).

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to provide respiratory care and services consistent with professional standards and deliver oxygen therapy according to physician orders (POs) for 1 of 2 residents (Resident 2) and 1 supplemental resident (Resident 60) reviewed for respiratory care. These failures placed residents at risk for potential negative outcomes such as under oxygenation, respiratory discomfort, and a decreased quality of life.Findings included . <Facility Policy> According to the facility's July 2018 Respiratory Care/Tracheostomy Care & Suctioning policy, the facility would ensure respiratory care and services were provided in accordance with professional standards of practice, resident Care Plans (CPs), and resident goals. Staff would assess and monitor resident respiratory status, including signs of shortness of breath and respiratory distress (unusual breathing patterns) and notify the physician of changes in condition. <Resident 2> According to the 03/20/2026 Significant Change Minimum Data Set (MDS - an assessment tool), Resident 2 had multiple diagnoses including kidney failure, depression, and dysphonia (voice disorder/impairment). This MDS showed Resident 2 had memory impairment and required no oxygen during the assessment period. Review of a 04/02/2026 PO showed an order directing staff to administer oxygen at one-to-four Liters Per Minute (LPM) via nasal cannula (NC - tubing with two short prongs placed in nostrils to deliver oxygen therapy) continuously to maintain oxygen saturation (a measurement of oxygen levels in the blood) more than 90% every shift for shortness of breath. Review of the 05/01/2026 Breathing difficulty related to intermittent dyspnea Care Plan (CP) showed instructions to the nursing staff to administer oxygen to Resident 2 via NC per PO. Observations on 04/30/2025 at 1:36 PM showed Resident 2 was lying in their bed and the NC was not in their nose. The oxygen concentrator (a device used to increase the concentration of oxygen inhaled) was turned on and set at two LPM. Observation and interview on 04/30/2026 at 1:54 PM showed Resident 2 lying in their bed and oxygen via NC was not in their nose. Resident 2 stated they were feeling short of breath and having hard time breathing. Observation on 04/30/2026 at 1:56 PM showed Resident 2's call light was turned on, and Staff U (Certified Nurse Assistant-CNA) came to the room to answer the call light. Staff U assessed Resident 2's oxygen saturation was 86%. Staff U raised Resident 2's head of bed up and oxygen saturation went up to 87-88%. Staff U noticed Resident 2's NC was not placed in their nostrils. Staff U then placed NC in Resident 2's nostrils. In an interview on 04/30/2026 at 2:00 PM, Staff X (Registered Nurse) stated staff assisted Resident 2 with feeding at lunch time and Resident 2 might have removed the NC from their nostrils. Staff X stated staff should check Resident 2 to make sure the NC was in their nostrils. In an interview on 05/06/2026 at 10:30 AM, Staff B (Director of Nursing) stated they expected nursing (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staff to follow the POs and check at least hourly to make sure resident's oxygen was on and in their nose, but they did not. <Resident 60> According to the 03/17/2026 Quarterly MDS, Resident 60 had diagnoses of medically complex conditions including respiratory problems, memory impairment, and altered level of consciousness with behavior fluctuations. Resident 60 required oxygen therapy. Review of a 04/29/2026 end stage respiratory disease CP showed staff were instructed to keep Resident 60's oxygen settings at two-to-four LPM via NC to keep oxygen saturation greater than 90%. Staff were instructed to monitor Resident 60 and report to the physician signs and symptoms of shortness of breath, increased breathing, accessory muscle use (neck and chest muscles) and decreased oxygen saturation. Observation and interview on 05/01/2026 at 9:11 AM showed Resident 60 self-propelled in their wheelchair from their room to the hallway, and approached this surveyor calling, Help! Help! Resident 60 was using their accessory muscles with forceful rise and fall of the chest to breathe. Resident 60 stated they were having shortness of breath. A portable oxygen tank hung on the back of Resident 60's wheelchair had no oxygen tubing connected. Staff M (Licensed Practical Nurse) assessed Resident 60's oxygen saturation and showed their oxygen saturation was 53%. Staff M left, and then brought a NC, connected it to the oxygen tank, and placed the NC in Resident 60's nostrils. Staff M reassessed Resident 60 and their oxygen saturation showed 53%. Staff F (Unit Manager) walked by and Resident 60 called out, Help! Help!. Staff F stated that Resident 60 was always low in oxygen saturation, was on hospice and had COPD. Staff F continued walking away from Resident 60. This surveyor stated to Staff F that Resident 60 oxygen saturation was 53% on oxygen, and they were still using their accessory muscles. Staff F then turned and walked toward Resident 60 and stated, How can I help you? Staff F and Staff M assisted Resident 60 back to their room and provided a respiratory treatment. Staff F reported to Staff M that Resident 60's oxygen saturation was 87%, and Resident 60 was back in the hallway. Observation showed Resident 60 sat in the hallway without the NC in their nostrils. Staff M reassessed Resident 60's oxygen saturation and showed it was 87%. Review of a PO summary on 05/01/2026 showed a 04/29/2026 order directing staff to maintain Resident 60's oxygen saturation above 90% by administering oxygen at two-to-four LPM via NC while sleeping and as needed, and Resident 60 may decline use. Review of Resident 60's documented vital signs showed the following: 04/04/2026 oxygen saturation 65% on room air (RA- without supplemental oxygen) 04/05/2026 oxygen saturation at 69% on RA, 04/11/2026 oxygen saturation at 55% on oxygen via mask, 04/15/2026 oxygen saturation at 66% on RA, 04/19/2026 oxygen saturation at 47% on oxygen via Mask, 04/28/2026 oxygen saturation at 77% on oxygen via NC, (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	04/29/2026 oxygen saturation at 88% on oxygen via NC, 04/30/2026 oxygen saturation at 79% on oxygen via NC. Review of Resident 60's April 2026 Medication Administration Record showed staff did not document the LPM of the oxygen administered to Resident 60 when oxygen was given, per PO. Review of Resident 60's progress notes from 04/01/2026 through 04/30/2026 showed staff did not document notification to the physician when Resident 60's oxygen fell below parameters, per PO. In an interview on 05/01/2026 at 11:25 AM with Staff A and Staff B, Staff B stated they expected staff to offer oxygen and care to Resident 60 according to the PO, and expected staff to document the LPM of oxygen administered. Staff B stated they expected staff to notify the physician when Resident 60's oxygen saturation fell below parameters as ordered. Reference WAC 388-97-1060 (3)(j)(vi)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide care in a manner that promoted dignity for 2 of 4 sampled residents (Residents 91 and 8) reviewed for dignity. The facility staff failed to provide Resident 91 with a privacy bag for their catheter, provide privacy while providing feeding tube care and put abdominal binder to protect feeding tube under their shirt for Resident 8. These failures placed residents at risk for feelings of diminished self-worth and embarrassment.Findings included . <Facility Policy> According to the facility's 09/20/2022 Respect and Dignity policy, residents had the right to be treated with respect and dignity. According to the facility's 04/2021 Urinary Catheterization, policy, the facility would provide care and services to support residents in the management of urinary catheters. <Resident 91> According to the 04/21/2026 admission Minimum Data Set (MDS-an assessment tool), Resident 91 admitted to the facility on [DATE] with diagnosis of Cancer and loss of bladder control. Record review of a 04/16/2026 urinary catheter Care Plan (CP) related to bladder cancer and urinary retention showed interventions included monitoring catheter function and providing catheter care every shift and as needed for Resident 91. In an observation on 04/29/2026 at 1:02 PM, Resident 91 was sitting in a wheelchair with the urinary drainage bag uncovered. In an observation on 04/30/2026 at 8:39 AM, Resident 91 was seen in the hallway with the urinary drainage bag exposed, and hanging on the wheelchair. In an observation on 04/30/2026 at 9:46 AM, Resident 91 returned to the facility in a wheelchair with their urinary bag attached to the wheelchair and uncovered. In an observation on 04/30/2026 at 1:55 PM, Resident 91 was sitting in their wheelchair in the hallway with the urinary bag uncovered and urine exposed. In an interview on 05/05/2026 at 10:01 AM, Staff E (Unit Manager) stated urinary drainage bags should be covered as it ensured the dignity of residents. In an interview on 05/06/2026 at 10:37 AM, Staff B (Director of Nursing) stated they expected staff to ensure residents urinary drainage bags were covered to provide resident privacy and dignity. <Resident 8> According to the 03/12/2026 Quarterly MDS, Resident 8 had some cognitive impairment and required extensive assistance from staff to meet their daily needs. The MDS showed Resident 8 required a feeding tube (artificial nutrition through a surgically implanted tube directly into their stomach) to (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	receive their medications and food. Review of the revised 04/21/2025 Nutritional Problem CP showed Resident 8 had pulled at their feeding tube and interventions directed staff to put an abdominal binder on Resident 8 when feeding tube was off during the daytime. In an observation on 04/29/2026 at 1:03 PM Resident 8 was up in their wheelchair with the abdominal binder on top of their shirt. In an observation on 05/04/2026 at 7:57 AM, Resident 8 was lying in their bed and had the abdominal binder on top of their shirt. In an observation and interview on 05/04/2026 at 11:43 AM, Resident 8 was sitting up in their wheelchair with the abdominal binder on top of their shirt. Resident 8 stated they did not know why they had the abdominal binder on top of their shirt. In an observation on 05/04/2026 at 11:47 AM Resident 8 was sitting up in their wheelchair in their room, privacy curtain and door was open, and Resident 8 was visible from the hallway. Staff Q (Registered Nurse) pulled Resident 8's shirt up and administered medication via feeding tube with no privacy. In an interview on 05/04/2026 at 2:20 PM, Staff Q stated they should have pulled the privacy curtain while providing medications via feeding tube to Resident 8, but they did not. When asked Staff Q about Resident 8 wearing abdominal binder on top of their shirt, Staff Q stated that it was to protect the feeding tube. In an interview on 05/06/2026 at 10:03 AM, Staff B stated their expectations from staff were to provide privacy while providing care including feeding tube care. Staff B stated they were aware of Resident 8 pulling at their feeding tube, but the abdominal binder should be under their shirt for dignity issues. Reference: WAC 388-97-0180 (1-4).

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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. Based on observation, interview and record review, the facility failed to ensure physician's orders (PO's) were followed for 2 of 5 residents (Residents 23 and 43) reviewed for unnecessary medications and 2 supplemental residents (Residents 91 and 11). The failure to follow orders for bowel protocols, to check ordered parameters for blood pressure (BP) medications, and to ensure topical medications were only given with a PO by qualified staff placed residents at risk for inappropriate treatment, unmet care needs, and other negative health outcomes.Findings included . <Facility Policy> Review of the undated Bowel Protocol and Bowel Tracking facility policy showed Bowel Movement (BM) frequency would be assessed by the nurse daily. Residents identified as having no bowel movement more than three days would be assessed by the nurse. The nurse would follow the bowel protocol by administering physician ordered stool softeners, laxatives and enemas (fluid administered rectally to treat constipation). <Bowel Protocol> <Resident 23> Review of the 03/10/2026 Annual Minimum Data Set (MDS - an assessment tool) showed Resident 23 had multiple diagnoses including constipation, was incontinent of bowel and dependent on staff for toileting hygiene. Review of a revised 07/29/2024 constipation Care Plan (CP) showed Resident 23 was at risk for constipation and staff were to follow the bowel protocol and keep the physician informed of any problems. Review of Resident 23's PO summary showed the following 04/12/2024 PO's: An oral laxative as needed for constipation, with no frequency indicated A different oral laxative if Resident 23 did not have BM for three days A suppository (medication administered rectally) to be given if no BM for four days An enema if the suppository was ineffective. Review of Resident's 23's April 2026 task documentation showed Resident 23 did not have a BM for five days, from 04/19/2026 through 04/23/2026, then had a BM on 04/24/2026. Review of Resident 23's April 2026 Medication Administration Record (MAR) showed staff did not administered the oral laxatives, suppository, or enema per PO. Review of Resident 23's progress notes showed no documentation that staff offered Resident 23 the bowel protocol medications or that they informed the physician of constipation concerns. <Resident 91> Review of the 04/21/2026 admission MDS showed Resident 91 had multiple diagnoses, including (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	constipation and impaired mobility of a lower extremity, was continent of bowel and dependent on staff for toileting hygiene. Review of a 04/16/2026 constipation CP showed Resident 91 had episodic constipation and staff were to follow the bowel protocol and keep the physician informed of any problems. Review of Resident 91's PO summary showed the following 04/15/2026 PO's: An oral laxative every 24 hours as needed for bowel care if no BM in three days A suppository if no BM for four days and if not relieved by oral laxative An enema to be given as needed for constipation if the suppository was ineffective Review of Resident's 91's April 2026 task documentation showed staff documented Resident 91 did not have a BM for five days, from 04/24/2026 through 04/28/2026, then had a BM on 04/29/2026. Review of Resident 91's April 2026 MAR showed staff did not administer the oral laxatives, suppository or enema per PO. Review of Resident 91's April 2026 progress notes showed no documentation that staff offered Resident 91 the bowel protocol medications or that they informed the physician of constipation concerns. In an interview and record review on 05/06/2026 at 10:37 AM, Staff B stated they expected staff to follow the bowel protocols and inform the physician of any problem relating to constipation. Staff B stated it was important to monitor residents for constipation and provide interventions as ordered to prevent bowel complications. Staff B reviewed Resident 23's and Resident 91's medical records and stated they did not see that any of the bowel protocols or interventions were followed. <BP Medication Parameters> <Resident 43> According to a 04/09/2026 admission MDS, Resident 43 had medically complex conditions including high BP, was usually understood, and sometimes understood others. Review of Resident 43's April 2026 MAR showed a 04/04/2026 PO for a BP medication to be given once daily between 6:00 AM and 10:00AM, and to hold (do not give) the medication for a systolic blood pressure (SBP – the top number in a BP reading) less than 100 or for a heart rate (HR) of less than 60. The MAR showed the medication was administered to Resident 43 daily from 04/04/2026 through 04/30/2026, with no documentation of Resident 43's SBP or HR. Review of Resident 43's April 2026 vital signs records and progress notes showed no documentation of SBP or HR results obtained at the scheduled time of the BP medication administration on the following days: 04/06/2026, 04/07/2026, 04/09/2026 through 04/14/2026, 04/16/2026 through 04/21/2026, and 04/23/2026 through 04/29/2026. In an interview on 05/05/2026 at 11:12 AM, Staff G (Unit Manager) confirmed that Resident 43 had a PO for daily blood pressure medication with parameters to hold the medication based on SBP and HR results. Staff G stated staff should check and document the SBP and HR each time prior to giving the (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication to determine whether to hold the medication, but they did not. In an interview on 05/06/2026 at 9:38 AM, Staff B said they expected staff to check residents' SBP and HR before administering medications when there were SBP and HR parameters. <Topical Medications with No PO, Unqualified Staff> <Resident 11> According to a 04/09/2026 annual MDS, Resident 11 had a progressive condition affecting the brain, had no speech, was sometimes understood and usually understood others. Resident 11 was dependent on staff for mobility, transfers, and hygiene, and had no existing skin conditions. Observation on 05/01/2026 at 8:48 AM showed Staff Z (CNA) provided a bed bath for Resident 11. Staff Z brought a basin of supplies to Resident 11's room, including a medicated topical cream and a medicated topical powder. Staff Z applied the cream to Resident 11's buttocks and applied the powder to Resident 11's groin area, chest, and under arms. Observation showed no redness or obvious skin issues in those areas. In an interview on 05/01/2026 at 9:25 AM, Staff Z stated that nurses told CNAs which cream or powder residents needed to prevent redness, and CNAs applied them. Staff Z stated CNAs obtained the needed supplies from the supply room. Review of Weekly Skin Checks completed on 04/24/2026 and 05/01/2026 showed Resident 11's skin was dry, warm, and intact with no skin concerns noted. Review of an 05/01/2026 Order Summary Report and an April 2026 MAR showed Resident 11 had no POs for the medicated topical cream or the medicated topical powder. In an interview on 05/05/2026 at 10:49 AM, Staff M (Licensed Practical Nurse) stated that CNAs were not supposed to apply topical medications. Staff M stated CNA's usually called the nurse to apply them while they cleaned the resident if topical medications were ordered. Staff M stated that staff needed to have a PO to apply topical medications, and they could not just decide what to apply on their own. In an interview on 05/05/2026 at 11:12 AM, Staff G stated that Resident 11 did not have a PO for the medicated cream or the medicated powder and staff should not have applied them. Staff G stated that if a resident needed a medicated topical treatment, a nurse would notify the doctor and obtain a PO. A nurse would then apply them as ordered. In an interview on 05/06/2026 at 9:38 AM, Staff B stated that medicated skin treatments required a PO, and nurses, not CNAs, should apply them. Reference: WAC 388-97-1620 (2)(b)(i)(ii)

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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 observation, interview, and record review, the facility failed to ensure staff used appropriate hand hygiene (HH) during incontinence for 1 supplemental resident (Resident 11) reviewed for incontinence care, and failed to ensure staff used Personal Protective Equipment (PPE) in accordance with Enhanced Barrier Precautions (EBP - infection control measure used to reduce the spread of multidrug-resistant organisms) for 1 of 3 sample residents (Residents 48) reviewed for skin conditions, 1 of 3 sample residents (Resident 71) reviewed for urinary catheters (flexible tube inserted into the bladder to drain urine) and 1 of 1 sample resident (Resident 8) reviewed for tube feeding (surgically implanted tube directly into the stomach to deliver nutrition, fluid and/or medications). These failures placed residents at risk for the development and transmission of communicable diseases and an unsanitary environment.Findings included <Facility Policy> According to the facility's reversed 06/08/2022 Infection Prevention and Control Program (IPCP) policy, staff were expected to followed standard and transmission-based precautions, utilize PPE appropriately, and monitor compliance with infection prevention practices. EBP was indicated for residents with wounds and indwelling medical devices, including urinary catheters and feeding tubes, and required staff to wear a gown and gloves during high-contact resident care. Staff were to perform HH, even if gloves were used, before and after contact with a resident, after contact with body fluids or visibly contaminated surfaces, and after removing PPE. <Hand Hygiene> <Resident 11> According to the 04/09/2026 annual Minimum Data Set (MDS - an assessment tool), Resident 11 had a progressive condition affecting the brain, was dependent on staff for mobility, transfers, and hygiene, and was always incontinent of bladder and bowel. Observation on 04/29/2026 at 12:37 PM showed Staff AA (Certified Nursing Assistant - CNA) provided incontinence care for Resident 11. While wearing gloves, Staff AA unfastened Resident 11's briefs (disposable incontinence product) and used a moistened wipe to clean urine and feces from Resident 11's peri area (genitals and buttocks). Using the same gloves and without performing HH, Staff AA applied a clean brief, adjusted Resident 11's clothing and bedding linens, used the bed controller to adjust the bed position, placed a mat on the floor by the bed, and moved Resident 11's wheelchair by holding onto the wheelchair handles. Staff AA removed their gloves, left the room to take a garbage bag to the soiled utility room, exited the soiled utility room, then performed HH. Observation on 05/01/2026 at 8:48 AM showed Staff Z (CNA) prepared to give Resident 11 a bed bath. Staff Z entered the room and put on gloves without performing HH. Staff Z used a towel, soap, and water to bathe Resident 11's body and their peri area, which was soiled with urine and feces. Without changing gloves or performing HH, Staff Z placed a clean brief under Resident 11, then applied a medicated cream to their buttocks, a medicated powder to their groin and upper body, and moisturizing lotion to arms and legs. Staff Z used a moistened wipe to clean off their gloves. Without changing gloves or performing HH, Staff Z fastened Resident 11's clean brief, dressed them in clothing, used the bed controller to adjust the bed position, and placed a fall mat on the floor. Staff Z (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505519	A. Building B. Wing	05/06/2026

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	removed their gloves and left the room without performing HH. In an interview on 05/01/2026 at 9:25 AM, Staff Z stated they were trained to perform HH before they enter a resident room, when they leave the room, after giving care, and when passing food trays. In an interview on 05/04/2026 at 12:55 PM, Staff C (Infection Preventionist) stated that there was an ongoing issue at the facility with staff not performing HH. Staff C stated staff should perform HH before and after contact with residents and before and after they go into resident rooms. Staff C stated when staff performed incontinence care, they should change gloves and perform HH when moving from a dirty area to a clean area. <EBP> <Resident 71> According to the 04/14/2026 Medicare - 5 Day MDS, Resident 71 readmitted to the facility on [DATE] and had Medically complex conditions including left side of the body weakness, kidney failure, and urinary retention. The MDS showed Resident 71 had an indwelling urinary catheter and required extensive assistance from staff to meet their daily needs. Review of the revised 04/28/2026 Enhanced Barrier Precautions related to indwelling catheter Care Plan (CP) showed directions for staff to use a gown and gloves during high contact resident care activities including dressing, bathing, transferring, changing linens, and changing briefs or assisting with toileting and/or indwelling catheter care. Observation on 04/29/2026 at 9:02 AM showed an EBP sign posted outside Resident 71's door. Observation on 05/04/2026 at 8:54 AM showed a privacy curtain was closed in Resident 71's room. This observation showed Staff Y (CNA) assisted Resident 71 with dressing, including to put their pants on while in their bed. Staff Y wore gloves, but did not wear a gown as directed in the CP. In an interview on 05/04/2026 at 9:00 AM, Staff C stated staff should wear a gown and gloves while providing direct care to Resident 71. Staff C stated staff should follow the directions related to EBP, but they did not. <Resident 8> According to the 03/12/2026 Quarterly MDS, Resident 8 had some cognitive impairment and required extensive assistance from staff to meet their daily needs. The MDS showed Resident 8 required a feeding tube. Review of the 03/31/2025 Enhanced Barrier Precautions related to feeding tube CP showed directions for staff to use a gown and gloves during high contact resident care activities included dressing, bathing, transferring, providing hygiene care, and using and/or providing feeding tube care. Observation on 04/30/2026 at 8:17 AM, showed Resident 8 was lying in bed and their feeding tube was disconnected from the tube feeding pump. Resident 8 had an EBP sign posted outside their door. Observation on 05/04/2026 at 11:47 AM showed Resident 8 sat in a wheelchair in their room while (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff Q (Registered Nurse) administered medication via their feeding tube. Staff Q did not wear gown. In an interview on 05/04/2026 at 12:37 PM, Staff Q stated EBP was indicated for residents at high risk for infection. Staff Q stated they should have worn a gown while providing feeding tube care, but they did not. In an interview on 05/06/2026 at 9:00 AM, Staff C stated staff should follow the care plans to wear PPE related to EBP. Staff C stated staff they expected staff to wear a gown and gloves while providing care to residents with feeding tube. <Resident 48> According to the 04/20/2026 annual MDS, with multiple diagnoses including a skin picking disorder, was dependent on staff to meet their daily needs, and was always incontinent of bladder and frequently incontinent of bowel. Review of a revised 03/31/2025 Enhanced Barrier Precautions related to chronic wounds CP showed Resident 48 was on EBP and caregivers should use a gown and gloves for high contact resident care activities including dressing, bathing, transferring, providing hygiene, changing linens, changing briefs and assisting with toileting, and wound care. Observation on 05/05/2026 at 11:19 AM showed no EBP signage posted at the resident's room door. Observation and interview on 05/05/2026 at 11:36 AM showed Staff L (CNA) completed incontinence care for Resident 48 without wearing a gown. Staff L stated they were not aware Resident 48 was on EBP as there was no EBP signage posted on their door. Staff L acknowledged Resident 48 had wounds and should be on EBP. In an interview on 05/05/2026 at 11:38 AM, Staff E (Unit Manager) stated staff were supposed to wear a gown and gloves when performing incontinence care for Resident 48. Staff E stated it was important for infection prevention and staff protection. In an interview and observation on 05/05/2026 at 11:46 AM, Staff C stated they expected staff to follow proper EBP practices, including wearing a gown and gloves, to prevent the spread of infection. Staff C stated staff had been trained on EBP precautions. Staff C stated EBP signage was to be placed on residents' doors for staff awareness. Staff C confirmed there was no signage on Resident's 48's door. In an interview on 05/06/2026 at 10:37 AM, Staff B (Director of Nursing) stated they expected staff to follow the policy for residents on EBP to ensure residents safety and prevent the spread of infection. Reference WAC 388-97-1320 (1)(2)(b)(5) .