

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505528	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2026
NAME OF PROVIDER OR SUPPLIER Lea Hill Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 32049 109th PI SE Auburn, WA 98092	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on observation, interview and record review the facility failed to implement their abuse policies and procedures including identification of an allegation of verbal abuse and neglect, protecting residents after an allegation of verbal abuse and neglect, making required notifications, logging the allegation on the abuse/incident log, completing an incident report, a thorough investigation, and post incident resident monitoring for psychological harm for 2 of 2 residents (Resident 1 & 2) reviewed for staff and resident incidents. These failures placed all residents at risk for unidentified abuse and neglect, on-going abuse, and diminished quality of life. Findings included. Review of the 10/05/2022 facility Abuse, neglect and Exploitation policy showed the facility would provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse and neglect. The policy showed verbal abuse was defined as the means of oral, written or gestured communication that willfully includes disparaging (belittle, demeaning, disrespectful) and derogatory terms towards residents regardless of their age or ability to comprehend. The policy defined neglect as failure to provide goods and services to a resident that were necessary to avoid physical harm, pain, mental anguish, or emotional distress. The policy showed the facility would have written procedures to assist staff to identify different types of abuse, an immediate investigation would be warranted when suspicion or reports of abuse or neglect occurred, the investigation would identify and interview all involved persons including witnesses and others that may have knowledge of the allegations, provide complete and thorough documentation of the investigation, staff would respond immediately to protect the alleged victim, and report immediately, but not later than two hours after the allegation was made if the events that caused the allegation involved abuse. <Resident 1> Review of the 04/28/2026 Minimum Data Set (MDS, an assessment tool) showed Resident 1 had mild cognitive impairment, was able to make their own decisions, and had diagnoses including heart failure, shortness of breath, and chronic respiratory failure that required Resident 1 to use oxygen continuously. The MDS showed Resident 1 was dependent on staff for toileting hygiene and transfers to/from bed to wheelchair and on and off the toilet. Review of a 04/08/2026 Activities of Daily Living (ADL) self-care deficit care plan showed Resident 1 required up to two-person assistance with dressing, toileting, and transfers. A 11/18/2025 at risk for falls care plan showed Resident 1 was at risk for falls due to poor balance, poor endurance, shortness of breath, and impaired strength. Review of a grievance form dated 05/06/2026 showed Staff D (Resident Care Manager/Licensed Practical Nurse (LPN)) filled out the form for Resident 1 for an incident that occurred on 05/05/2026 in the evening. The grievance showed Resident 1 had concerns that Staff G (Certified Nurse Assistant) assisted them to the bathroom without their oxygen, left them on the toilet and the resident had to walk themselves back to their bed, and Staff G told Resident 1, I should not have to help you, you can take yourself. Review of Resident 1's nursing progress notes dated 05/05/2026-05/12/2026, showed no indication the facility documented the incident, reported the allegation to the Physician, and monitored the resident for psychological harm post incident. Review of a 05/07/2026 Grievance Investigation Report, showed Staff B (Director of Nursing) interviewed Resident 1 regarding their concerns about staff conduct and assistance with care needs. Resident 1 told Staff B they requested a nightgown from Staff G, they left the room, came (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 505528	Facility ID: 505528 If continuation sheet Page 1 of 4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505528	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2026
NAME OF PROVIDER OR SUPPLIER Lea Hill Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 32049 109th PI SE Auburn, WA 98092	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	back and tossed the nightgown towards the resident. Resident 1 told Staff G they needed assistance with their nightgown and Staff G placed it on Resident 1's lap and did not assist the resident to put on the gown. Resident 1 told Staff B that Staff G stated, what else do you want? and Resident 1 requested assistance to the bathroom and Staff G responded, you look perfectly capable of doing it by yourself. Resident 1 told Staff G they were not cleared to ambulate independently by physical therapy and recently experienced four falls, Staff G left the room, did not return, and Resident 1 had to urgently use the bathroom, ambulated themselves without assistance, and made it to the bathroom but was dizzy and weak from not wearing their oxygen. Resident 1 stated they activated their call light in the bathroom, Staff G returned and stated to Resident 1, Oh, so I see someone learned to use their legs. Resident 1 told Staff B these interactions made them feel unsafe, unsupported and concerned about their well-being and informed Staff D who assisted them to fill out a grievance form. In a phone interview on 06/16/2026 at 11:30 AM Resident 1 stated Staff G refused to assist them to the bathroom, they had no choice but to ambulate without assistance to the bathroom because they were afraid, they would have an accident and wet themselves. Resident 1 stated it made them angry and upset because Staff G didn't listen to what they had to say, was unprofessional, it took them a lot longer to get themselves to the toilet, they were not cleared by therapy to ambulate alone, and they were taking the risk of falling. <Resident 2> Review of a 04/27/2026 admission MDS showed Resident 2 was able to make their needs known, own decisions, had no cognitive deficits, and had diagnoses including acute respiratory failure, diabetes, and a neurological disorder. The MDS showed Resident 2 was dependent on staff for toileting hygiene, lower body dressing, bed mobility, and transfers to/from the bed. Review of a 04/20/2026 ADL self-care deficit care plan showed Resident 2 required assistance with bed mobility, bathing, dressing, and transfers. A 04/20/2026 fall risk care plan showed Resident 2 was at risk for falls related to impaired vision, impaired strength, pain, and shortness of breath with exertion. Review of a grievance form, dated 05/07/2026, showed Staff H (Social Worker) filled out a grievance form for Resident 2 that showed on the evening of 05/05/2026 Resident 2 had felt that Staff G was disrespectful. Resident 2 told Staff H that they requested assistance from Staff G who was on their cellphone the whole time. Resident 2 called again to get assistance with picking a remote off the floor and Staff G told Resident 2, you call too much, picked up the remote and left the room. Review of Resident 2's nursing progress notes dated 05/05/2026-05/12/2026, showed no indication the facility documented the incident, reported the allegation to the Physician, and monitored the resident for psychological harm post incident. Review of a 05/07/2026 Grievance Investigation Report showed Staff B interviewed Resident 2 regarding concerns of feeling disrespected by Staff G. Staff B documented that Resident 2 stated during their interactions with Staff G, staff remained on their cell phone, they had concerns regarding the interactions and reported their concerns to staff. The grievance investigation report showed Staff B would interview staff and review Resident 2's medical record. Attempts to interview Resident 2 on 06/16/2026 at 1:08 PM were unsuccessful as the resident had been discharged from the facility and no return call was received. Review of a 05/07/2026 investigation summary showed Staff B documented the facility received allegations on 05/07/2026 from two residents regarding Staff G's disrespectful communication, failure to provide requested assistance, distracted care while speaking on the phone, Resident 1 attempting ambulation without assistance despite a history of falls and need for oxygen therapy, and both resident's perceptions of these interactions as dismissive and demeaning. The summary showed that Staff G was immediately removed from assignment involving the resident's who reported concerns and nursing leadership had initiated staff interviews, review of relevant documents, the investigation remained on-going, and additional interviews, documentation review, and determination findings would be completed in accordance with the facility policy and regulatory requirements. Review of a 05/12/2026 investigation conclusion showed Staff B reviewed all information, statements, and could not substantiate the allegations, as the findings were inconclusive and based on conflicting accounts between the resident and Staff G who denied all (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505528	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2026
NAME OF PROVIDER OR SUPPLIER Lea Hill Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 32049 109th PI SE Auburn, WA 98092	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	allegations made against them. Review of the May 2026 facility abuse log showed no indication staff logged Resident 1 and Resident 2's allegation of verbal abuse and neglect. Review of Staff G's timecard showed on 05/05/2026, the date the allegation was received by Staff D, that Staff G worked 6:01 AM-2:05 PM in the memory care center and 2:10 PM-10:04 PM in the care center. The documentation showed Staff G was not removed from all resident care after the allegation was made in the evening and was allowed to continue to work with other residents. The timecard showed on 05/06/2026 and 05/07/2026 Staff G worked both days from 6:00 AM-2:00 PM in a memory care unit, indicating they were not removed from the floor after the allegation and continued to work with other residents. In an interview and observation on 06/04/2026 at 1:08 PM Resident 3 was observed sitting in their wheelchair knitting. Resident 3 stated there was a female staff member, they did not recall their name, but the staff member was on their cell phone during care. Resident 3 stated they were on the toilet and the staff was not aware as they were distracted by their cell phone. Resident 3 stated this made them upset, they hate to complain, ended up sitting on the toilet for 20 minutes, and the staff member told them, You are okay, I'll be back. Resident 3 found it offensive, stated cell phones should not be allowed in the care area, and left in the breakroom. In an interview on 06/04/2026 at 1:34 PM Staff E (Registered Nurse, RN) stated verbal abuse was being rude, yelling, or raising your voice and neglect was when care services were not provided to the resident. When asked what they would do when a resident made a statement that a staff member was rude and refused to toilet them, Staff E stated they would first talk to the resident, then talk with staff, and then report to the management who would have a meeting to discuss the incident. When asked if the staff member should be removed from the floor, Staff E stated the staff would be restricted from going into the room of the resident who made the complaint and if it was a serious complaint then they would remove the staff from the floor. When asked how to identify a serious complaint from a not serious complaint Staff E stated it depended on how upset the resident was. When asked how they would ensure the staff did not continue to verbally abuse and neglect other residents if they were allowed to continue to work on the floor, Staff E then stated the staff should be removed from the floor. During an interview on 06/04/2026 at 1:45 PM, Staff F (Licensed Practical Nurse, LPN) stated verbal abuse was anything that hurt a resident's feelings, like being rude, yelling, acting bothered by the resident's requests and neglect was not providing care to a resident who needs the care. Staff F stated if a resident alleged verbal abuse or neglect they would talk to the resident, talk to the staff and remove the staff from caring for the resident who made the complaint. Staff F stated if it was unsafe then they would send the staff member home. When asked how they determined if it was unsafe, Staff F stated they would talk with the resident and see their behavior, if the resident felt unsafe, they would send the staff member home. When asked how they would ensure the staff member did not continue to verbally abuse or neglect the other residents if not sent home, Staff F hesitated and stated the staff member should be sent home after a resident made an allegation or complaint that was considered abuse. During an interview on 06/04/2026 at 1:51 PM Staff C (Infection Preventionist/LPN) stated staff should have but did not remove Staff G immediately after the allegation was made on 05/05/2026 to ensure all residents were protected from abuse. Staff C reviewed Resident 1 & Resident 2's medical record and stated there were no progress notes on the incident, no documentation of physician notification, and no documentation of post incident monitoring for psychological harm, no social services follow-up after the incident, and would expect the documentation to be in the resident's records. Staff C reviewed the abuse/incident log and stated the allegations for both Resident 1 and Resident 2 were not but should be on the abuse log. When asked to provide staff interviews for the investigation, Staff C stated they did not know if Staff B had completed staff interviews for the investigation, could not find staff interviews, and would expect staff working on 05/05/2026 to be interviewed about witnessing any events or interactions related to the allegations. In an interview on 06/04/2026, Staff A (Administrator) stated they could not produce documents but would expect a thorough investigation, an incident report to be completed, thorough (continued on next page)		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505528	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2026
NAME OF PROVIDER OR SUPPLIER Lea Hill Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 32049 109th PI SE Auburn, WA 98092	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation of the incident including physician notification, resident alert charting and monitoring for psychological harm, an allegation of neglect or abuse to reported immediately, and the staff removed from the floor immediately following the allegation. REFERENCE: WAC 388-97-0640(2)(b)(5)(6)(a-b)		