STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505294	A. Building B. Wing	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beacon Hill Rehabilitation	128 Beacon Hill Drive Longview, WA 98632

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 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51254 Based on interview and record review, the facility failed to ensure ongoing physician notifications were made when the resident experienced a change of condition in conjunction with a medication discontinuation and the need for a significant change in treatment for 1 of 7 sampled residents (162) reviewed for notification of change. Resident 162 experienced harm when the resident had ongoing increasing visual hallucinations (mice, snakes, does not feel safe, lost appetite due to snakes in the resident's room, people in the resident's room, tadpoles, river rats that can bite you, being held hostage, and stated, This is terrible.) and the physician was not consulted about the ongoing increasing hallucinations and a significant need for treatment. This failure placed residents at risk for untreated medical conditions and a diminished quality of life. Findings included . Resident 162 was admitted to the facility on [DATE]. The 5-day Minimum Data Set (MDS) assessment, dated 12/05/2024, indicated Resident 16 was moderately cognitively impaired. Physician orders showed Resident 162 was started on Seroquel (an antipsychotic medication used to treat psychosis and other major psychological mood disorders) 50 mg orally at bedtime for hallucinations during the resident's most recent hospitalization and when readmitted to the facility on [DATE]. A pharmacist recommendation, signed by the physician on 01/09/2025, reduced Resident 162's Seroquel dose to 25 mg orally for 1 week, and then to stop the Seroquel medication. A nursing note, dated 01/12/2025 at 10:10 AM, documented, Res [Resident 162] on alert for decreased Seroquel order. Res vital signs stable; when asked how [the resident] slept, res stated . restless 'because of the mice.' LN [Licensed Nurse] asked [the resident] to clarify if . hearing or seeing the mice. Res stated . was 'watching them run across the ceiling.' Res was matter of fact when reporting and was not in distress related to the 'mice.' The electronic health record (EHR) showed Resident 162's Seroquel ended on 01/15/2025 per pharmacy recommendations. (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 0580 Level of Harm - Actual harm Residents Affected - Few	A nursing note, dated 01/17/2025 at 12:26 AM, documented, Res c/o [complained of] having some cannabis missing from [the resident's] room, as well as seeing mice and snakes coming out of the vents in the walls. Assured [the resident] is safe and no mice or snakes are in [the resident's] room. A nursing note, dated 01/18/2025 at 1:02 AM, documented, Res is received in bed awake. Res talking about people in [the] room looking at [the resident]. Res states . doesn't feel safe. Res is assured no one was in [the] room. A nursing note, dated 01/19/2025 at 3:40 PM, documented, On alert for c/o seeing 'snakes' in [the] room. Res declined eating lunch, indicating [a lost appetite] after seeing 'snakes.' [Resident 162] indicated [knowing] it is in [the resident's] head, but it is bothersome. A nursing note, dated 01/20/2025 at 4:21 AM, documented, Res cont [continues] with hallucinations. Res stated [knowing] the 'snakes,' 'tadpoles,' and 'mice' are not real, but . can still see them. Upon giving scheduled medication, res stated . wasn't sure if this LN was real. Reassured and reoriented res. An eMAR-Medication Administration Note, dated 01/27/2025 at 5:53 AM, documented, Res cont with hallucinations. Res hollering for help when awake this shift. Res adamant that there's a river rat in [the] room. Tried to reassured res, but res was insistent it was there and had this LN put [the resident's] shoes on while in bed so that the river rat would not be able to bite [the resident's] feet. NAC [Nursing Assistant Certified] reported to this LN that res thinks we're keeping [the resident] hostage. Had to reorient and reassured res multiple times as res thinks this LN also in danger. A eMAR-Medication Administration Note, dated 01/29/2025 at 12:07 PM, documented, This shift LN went into [Resident 162's] room [ROOM NUMBER] times to provide care. Each time resident was experiencing hallucinations. 'This is terrible. You couldn't have children with this.' Resident referring to hallucinations, dog, cat, snake. On 03/06/2025 at 9:01 AM, Staff B, Director of Nursing Services (DNS) and a Registered Nurse (RN), said Resident 162 was started on Seroquel for delirium while at the hospital and no longer needed the medication. Staff B said after reviewing Resident 162's medical record, the medical director was notified by e-mail of these distressing hallucinations on 01/20/2025 with physician's direction to continue to monitor. When asked to provide further notifications to the physician regarding Resident 162's ongoing hallucinations over the next 10 days, Staff B indicated she was unable to provide documentation of further physician notifications. Staff B said there should have been notes in the chart reflecting the nurses had reported Resident 162's ongoing hallucinations to the physician. Reference WAC 388-97-0320 (1)(b)(c)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37934 Based on interview and record review, the facility failed to ensure resident centered activities were provided that incorporated the resident's preferences for 1 of 4 sampled resident (37) reviewed for activities. This failure placed residents at risk for a diminished quality of life. Findings included . Resident 37 was admitted to the facility on [DATE]. The Admission's Minimum Data Set assessment, dated 11/06/2024, showed the resident was alert and oriented and preferred to have books, newspapers and magazines. The Activity - Admission Evaluation, dated 01/24/2024, documented activities will provide car magazines. The Activity - Quarterly Evaluation, dated 01/23/2025, documented activities has provided Resident 37 with car magazines. The February 2025 and March 2025 activity participation reports did not show Resident 37 had been offered and/or refused car magazine. On 03/04/2025 at 8:37 AM, Resident 37 said one of his activity preferences was cars or motorsports. Resident 37 said he would be interested in magazines or books related to motorsports if offered. On 03/06/2025 at 10:33 AM, Staff H, Activities Director, said if a resident had a preference for an activity they would do what they could to meet that resident's preferences. Staff H said they have supplied magazine, books, calendars and pictures. At 2:10 PM, Staff A, Administrator, said activities should develop a plan for the resident's preferences and provide services. Reference WAC 388-97-0940 (1)(2)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51254 Based on observations, interview and record review, the facility failed to ensure physician orders were implemented for edema (the presence of excessive fluid in the body tissue) treatment for 1 of 1 sample resident (21) and failed to ensure bowel interventions were initiated for 1 of 5 sample residents (24) reviewed for quality of care related to following physician orders and bowel management. These failures placed residents at risk of complications related to untreated medical conditions and a diminished quality of life. Findings included . <Edema> Resident 21 was admitted to the facility on [DATE] with diagnoses including chronic congestive heart failure. The 5-day MDS Assessment, dated 01/28/2025, indicated Resident 21 was moderately cognitively impaired. A Physician order, dated 01/31/2025 at 8:00 PM, indicated Resident 21's ted hose (a type of compression stocking used to treat swelling) were to be put on in the morning and to be taken off at bedtime for the treatment of edema. On 03/03/2025 at 3:06 PM, Resident 21 was observed sitting on the side of the bed and indicated her right leg was so swollen that fluid was starting to leak through the skin. There was visible moisture on the outer calf side of Resident 21's right leg. Resident 21 said her right pant leg was wet, and the pant leg did appear to be damp. Resident 21 was not wearing the ted hose. When asked if she had ever used compression stockings, Resident 21 stated, Oh, they talked about it, but that is all that ever happened. I have never been given any. On 03/04/2025 at 3:40 PM, Resident 21 was observed sitting on the side of the bed and not wearing the ted hose. Resident 21 said by the evening time she had to change her pants due to the moisture from the right leg dripping onto her clothing. On 03/05/2025 at 8:48 AM, Staff D, Nursing Assistant (NA), said for residents that wore ted hose, there would be a place on the task list to prompt the nursing assistants to put on the ted hose. Staff D said there would also be a prompt for removing them in the evening. Staff D said Resident 21 did not wear the ted hose. Staff D indicated they were unable to find a cue on the task list indicating the placement of ted hose for Resident 21. At 9:10 AM, Resident 21 was observed sitting on the side of the bed and not wearing the ted hose. Resident 21's legs were visibly swollen. At 9:10 AM, when asked to assess Resident 21's edema and locate the physician order for ted hose, Staff C, Licensed Practical Nurse and Resident Care Manager (RCM), Resident 21's legs were observed to be visibly swollen and shiny in appearance. Staff C asked Resident 21, Where are your compression stockings. Resident 21 stated, I have never had any. They talked about getting me some, but that's it. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/06/2025 at 9:01 AM, Staff B said the nurse would tell the nursing assistant verbally to put on ted hose for a resident. Staff B said the nurses should chart in the EHR if the resident refused the treatment. Staff B was unable to find documentation for refusals in Resident 21's EHR. At 3:10 PM, Staff E, NA, said she would find information about ted hose in the charting area of the EHR. Staff E said she worked during the evening time, and would be responsible to take the [NAME] hose off if a resident was wearing them. Staff E said she had never seen any of the residents have [NAME] hose, including Resident 21. 37934 <Bowel Interventions> A facility's document entitled, Bowel Protocol, undated, documented, If no BM (Bowel Movement) after 4 days: 1. Administer Miralax (Laxative) 17gm (grams) in 6-8oz (ounces) of choice of beverage on day shift of day 4. Resident 24 was admitted to the facility on [DATE]. The Annual MDS assessment, dated 11/26/2024, showed the resident was alert and oriented. The BM task sheet documented Resident 24 had a BM on 02/18/2025 at 8:10 PM. Resident 24's next BM was on 02/23/2025 at 12:59 PM, over 112 hours, five days since the last BM. The February 2025 Medication Administration Record did not show documentation Resident 24 received any interventions between 02/18/2025 and 02/23/2025. On 02/07/2025 at 9:40 AM, Staff F, RCM and Licensed Vocational Nurse, said the bowel protocol should be initiated if the resident did not have a bowel movement after four days. After reviewing Resident 24's Bowel task, Staff F said the bowel protocol should have been initiated on 02/22/2025. At 9:29 AM, Staff B said the bowel protocol should be initiated on day 4 of no BM's. After reviewing Resident 24's Bowel task, Staff B said the bowel protocol should have been initiated on 02/22/2025. Reference WAC 388-97-1060 (1)(3)(c)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51254 Based on observations, interviews and record review, the facility failed to ensure oxygen therapy was accurately monitored for 1 of 4 sampled residents (21) reviewed for oxygen therapy. This failure placed residents at risk for a compromised respiratory status and a decreased quality of life. Findings included . The facility policy/procedure for oxygen administration, updated 02/2023, indicated the facility will document all appropriate information in the medical record including oxygen therapy, respiratory assessment findings, method of oxygen delivery, flow rate, resident's response, any adverse reactions or side effects. Resident 21 was admitted to the facility on [DATE] with diagnoses including oxygen dependence related to chronic respiratory failure. The 5-day Minimum Data Set assessment, dated 01/28/2025, indicated Resident 21 was moderately cognitively impaired. The physician order for oxygen therapy, dated 01/23/2025, indicated oxygen was to be delivered at 2L/min (liters per minutes) when at rest, or 2-3L/min with activity. On 03/03/2025 at 1:34 PM, Resident 21 was observed sitting on the side of their bed with oxygen delivery. The oxygen concentrator dial indicated 3.5 L/min of oxygen was being administered. On 03/04/2025 at 3:49 PM, Resident 21 was observed in their bed receiving oxygen with the concentrator dial set to 3.5 L/min. On 03/5/2025 at 8:47 AM, Resident 21 was observed sitting on the side of their bed receiving oxygen with the concentrator dial set to 3.5 L/min. At 9:10 AM, Staff C, Resident Care Manager and Licensed Practical Nurse, said the oxygen order was determined by the nurse. The determination would be made to increase the oxygen setting if the resident was working with therapy and required more oxygen. Staff C indicated she was unable to find the amount of oxygen Resident 21 was receiving in the medical record. On 03/06/2025 at 9:01 AM, Staff B, Director of Nursing of Services and Registered Nurse, said the nurses monitor the oxygen on the Medication Administration Record. Staff B indicated she was unable to provide documentation showing Resident 21's oxygen use was being monitored as per the oxygen order. Reference WAC 388-97-1060 (3)(j)(vi)