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	05/21/2026

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure 1 of 3 residents (Resident 43) was free from physical restraints. This failure placed residents at risk of injury and a decreased quality of life.Findings included.Resident 43 was admitted to the facility on [DATE]. The 5-Day Minimum Data Set (an assessment tool), dated 03/02/2026, indicated Resident 43 was alert and oriented.During an observation and interview on 05/19/2026 at 9:02 AM, Resident 43's bed was observed against the wall on the window side of the room. Resident 43 said the bed had always been like that.During an observation on 05/20/2025 at 2:36 PM, Resident 43's bed was still against the wall.Record review of Resident 43's electronic health record did not have an an assessment, consent, care plan or a physician's order regarding Resident 43's bed against the wall.During an observation and interview on 05/20/2026 at 2:45 PM, Staff H, Resident Care Manager/Licensed Practical Nurse, said before a bed was placed against a wall the facility would do a safety assessment, get consent, get an order, and update the care plan. When asked about Resident 43's bed against the wall, Staff H said Resident 43 did not have an intervention for his bed to be against the wall. When we went to the room Staff H said the nursing assistant could have accidentally pushed the bed against the wall. Staff H said the bed should not be there.Reference WAC 388-97-0620 (1)(B)

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the Minimum Data Set (MDS, an assessment tool) was completed accurately to reflect a resident's health status and/or care needs for 1 of 8 sampled residents (Resident 7) reviewed for physical restraints and unnecessary medications. This failure placed residents at risk for unidentified and/or unmet care needs and a diminished quality of life.Findings included. Resident 7 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented Resident 7 was severely cognitively impaired, did not use a wander/elopement alarm (Wander Guard, a security system that uses a wearable tag and/or sensor designed to prevent people with cognitive impairments from leaving secure areas to ensure their safety, by triggering alerts to caregivers), was taking anticoagulant medication (blood thinner medications that slow down or prevent blood clots), and was not taking antiplatelet medication (medications that stop blood cells from sticking together). Record review of Resident 7's physician orders, dated 11/19/2025, documented, LN [licensed nurse] to monitor wander guard placement to left ankle every shift. Record review of Resident 7's physician orders, dated 12/02/2025, documented, Check wander guard placement Qshift [every shift] Left ankle . Record review of Resident 7's care plan, dated 11/22/2025, documented, [Resident 7] Utilizes enabling devices.Wander guard.Check wander guard placement Qshift. In an observation on 05/20/2026 at 9:23 AM, Resident 7 was observed sitting in a chair in the third-floor lobby with a Wander Guard alarm bracelet attached to her left ankle. Record review of Resident 7's physician orders, dated 11/12/2025, showed Resident 7 was prescribed Clopidogrel, an antiplatelet medication. Further review of Resident 7's physician orders did not show Resident 7 was prescribed anticoagulant medications. Record review of Resident 7's May 2026 Electronic Medication Administration Record, showed Resident 7 was taking Clopidogrel daily. In an interview on 05/21/2026 at 9:05 AM, Staff D, Resident Care Manager/Licensed Practical Nurse, said the Wander Guard was not captured on Resident 7's MDS and it should have been, stating, I missed that. When asked about Resident 7's MDS coded for anticoagulant medication use and no antiplatelet medication use, Staff D said he thought the Clopidogrel medication was an anticoagulant, not an antiplatelet. In an interview on 05/21/2026 9:43 AM, Staff B, Director of Nursing/Registered Nurse, indicated Resident 7's Wander Guard should have been captured on the MDS. Staff B said Clopidogrel was not an anticoagulant and should not have been coded as one. Reference WAC 388-97-1000 (1)(b)(n)

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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** Based on observation, interview, and record review, the facility failed to ensure physician orders and/or care plans were followed for 1 of 5 sampled residents (Resident 30) reviewed for unnecessary medications, 1 of 4 sampled residents (Resident 2) reviewed for accidents, and 1 of 1 sampled resident (Resident 4) reviewed for antibiotic use. This failure placed residents at risk of injury, unmet care needs, and a diminished quality of life.Findings included . Resident 30 was admitted to the facility on [DATE]. The admission Minimum Data Set (MDS), an assessment tool, dated 04/16/2026, indicated Resident 30 was alert and oriented. Record review of Resident 30's physician's order, dated 04/10/2026, showed Resident 30 was prescribed Oxycodone (a narcotic pain medication) tablet, Give 1 tablet by mouth every 6 hours as needed for PAIN (LEVEL 6-10) NOT RELIEVED BY NON-OPIOD [sp] TX [treatment]. Record review of Resident 30's electronic Medication Administration Record (eMAR), dated 04/14/2026, documented Resident 30 was given an Oxycodone tablet for a pain level of 4. Record review of Resident 30's eMAR, dated 05/08/2026, documented Resident 30 was given an Oxycodone tablet for a pain level of 5. Record review of Resident 30's eMAR, dated 05/18/2026, documented Resident 30 was given an Oxycodone tablet for a pain level of 3. During an interview on 05/21/2026 at 9:52 AM, Staff I, Licensed Practical Nurse, said if a resident complained of pain, they would try non-pharmacological interventions first if that did not provide relief then they would give the resident pain medication as prescribed. Staff I said she would follow the parameters as set forth by the physician. During an interview on 05/21/2026 at 10:20 AM, Staff B, Director of Nursing/Registered Nurse (RN), said nurses should assess the pain level, attempt non-pharmacological interventions, and then follow the parameters for pain medication if needed. Staff B said Resident 30 should not have been given Oxycodone for a pain level of 3 to 5. Staff B said the nurse should have contacted the provider to get a new order if Oxycodone was needed. Resident 2 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented Resident 2 was moderately cognitively impaired. Record review of Resident 2's physician orders, dated 11/18/2025, documented, .FALL MATS TO RIGHT AND LEFT SIDES OF BED. Record Review of Resident 2's enabling devices care plan, dated 11/18/2025, documented, .fall mats to right and left sides of bed. In an observation on 05/18/2026 at 12:45 PM, Resident 2 was observed lying in bed with a fall mat on the floor to the left side of the bed. No fall mat was observed on the floor to the right side of the bed. In an observation on 05/18/2026 at 3:48 PM, Resident 2 was observed lying in bed with a fall mat on (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the floor to the left side of the bed. No fall mat was observed on the floor to the right side of the bed. In an observation on 05/19/2026 at 8:58 AM, Resident 2 was observed lying in bed with a fall mat on the floor to the left side of bed. A second fall mat was observed to the right side of the bed leaning up on its edge against the open closet. In a joint observation and interview on 05/19/2026 at 12:45 PM, Staff F, RN, went to Resident 2's room and observed a fall mat on the floor to the left side of the bed, and a mat to the right side of the bed leaning up on its edge against the open closet. Staff F pointed to the fall mat on the right side of the bed leaning on its edge and said she did not know why that fall mat was there. Staff F left the room and looked at Resident 2's Electronic Health Record, stating, It does definitely say fall mats to the right and left side of the bed. In an interview on 05/19/2026 at 1:40 PM, Staff B said she expected both fall mats to be down on the floor if that's what was ordered. Resident 4 was re-admitted to the facility on [DATE]. The Admission/Medicare – 5-day MDS, dated [DATE], documented Resident 4 was severely cognitively impaired and was on IV (intravenous, a method to administer fluids, medications, or nutrients directly into the bloodstream through a vein) medications. Record review of Resident 4's physician orders, dated 04/24/2026, documented, PICC [Peripherally Inserted Central Catheter, a type of long-term IV in the upper arm] Dressing change weekly every day shift every 7day(s) for PICC line w/ [with] IV ABO [antibiotic]. In an observation on 05/18/2026 at 3:02 PM, Resident 4 was observed lying in bed. An IV site with a dressing was observed on Resident 4's upper left arm that was dated 5/9, nine days ago. In an interview and observation on 05/18/2026 at 3:10 PM, Staff G, RN, said PICC dressings were changed every seven days. Staff G went to Resident 4's room and looked at the PICC dressing on Resident 4's upper left arm, stating, It does say 5/9 as the date on the dressing. Staff G said she would need to ask Staff J, Infection Preventionist /RN if a PICC dressing change should be done every seven or 10 days. In a joint interview on 05/18/2026 at 3:18 PM, Staff J and Staff B said PICC line dressings should be changed every seven days. In an interview on 05/19/2026 at 1:44 PM, Staff B said the dressing change for Resident 4's PICC was a missed treatment. Reference WAC 388-97-1060(1)(3)(g)(k)(i)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review, and interview, the facility failed to ensure food items were properly stored in 2 of 5 walk-in facility refrigeration devices. This failure placed residents at risk for food borne illness, and a diminished quality of life. Findings included . Record review of the facility policy, titled, Policy/Procedure-Food Storage, revision date February 2025, documented, Food Rules As Follows:Please label and date all items you place in the refrigerator with a ?UB' or Use By Date.The Used By label is good for 2 days after date it is placed. Total 3 days.All items in the refrigerator past the UB Date will be discarded.Any perishable, non-sealed, no-marked item will be discarded for prevention of food borne illness. During an observation on 05/18/2026 at 9:54 AM, the kitchen walk-in refrigerator was observed with the following undated, opened items: Two plates containing two tuna salad sandwiches each, wrapped in plastic wrap, labeled with UB date of 05/17/2026.Six lbs (pounds) plastic container of salsa, opened and unlabeled.Five lbs plastic resealable bag of pepperoni, opened and unlabeledBlock of sliced American cheese, opened, undated and stored with plastic wrapping coming undone, exposing the cheese.16 oz (ounces) of Whipped Topping, opened and cut on bottom corner, unlabeled and stored with plastic wrapping coming undone, exposing the topping. During an observation on 05/18/2026 at 10:01 AM, the outside walk-in freezer, was observed with the following undated, opened items: Plastic bag of meatless chicken bites, opened and unlabeled In an interview on 05/18/2026 at 10:07 AM, Staff E, Dietary Manager, said the items going into the food storage areas should be labeled with a use by date, and should be discarded by that date. Staff E proceeded to discard all unlabeled items, and stated, Yes, all that should be tossed. In an interview on 05/21/2026 at 9:52 AM, Staff A, Administrator, said he expected food items in the refrigerators to be labeled accurately and discarded by the use by date. Reference WAC 388-97-1100 (3) & 2980