STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505216	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Soundview Rehabilitation and Health Care Inc	1105 27th Street Anacortes, WA 98221

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on interview and record review the facility failed to prevent the loss of controlled (narcotic) medications for 1 of 1 sampled resident (Resident 3) reviewed. This failure resulted in Resident 3's narcotic pain medication being diverted within the facility, and Resident 3's controlled medication for use other than their pain management program. Findings included . Review of the facility's policy titled Controlled Substances, dated 02/26, documented controlled medications as substances that have an accepted medical use and have a potential for abuse. These medications are subject to special handling, storage, disposal, and record keeping at the center, in accordance with federal and state laws and regulations. Resident 3 was admitted to the facility with a diagnoses to include chronic pain, a broken right rib bone, and arthritis. Review of Resident 3's physician order, dated 03/11/2026, documented an order for oxycodone (a narcotic pain medication) 5 milligrams (mg) every four hours as needed for moderate pain. Review of a facility investigation report, dated 04/11/2026, documented during a controlled substance medication count with Staff F, Registered Nurse (RN)/off going nurse and Staff G, Licensed Practical Nurse/oncoming nurse, Resident 3's card of oxycodone 5 mg tablets was missing. There were 23 missing tablets documented. The facility conducted a search of the facility and could not locate the missing card of oxycodone. The facility concluded that the medication was not deliberately taken and it was discarded into the garbage. Local law enforcement (LE) was not notified. Review of Resident 3's pharmacy bill, invoice date 04/30/2026, documented the facility reordered the oxycodone on 04/11/2026 and Medicare part A was charged for the missing medications. The facility did not reimburse the resident for the missing medications. A joint interview was conducted on 06/04/2026 at 2:32 PM with Staff A, Chief Executive Officer and Staff B, RN/Chief Nursing Officer. When asked if the facility paid for the misappropriation of Resident 3's medication, both stated no. Staff A and Staff B stated the local LE was notified of the potential theft/missing oxycodone. Refer to WAC 388-97-0640(2)(a), (3)(d)

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure 1 of 1 resident (Resident 2) was adequately monitored and supervised while walking to the emergency room (ER). This failure placed residents at risk for fall and injury. Findings included.Review of the policy titled Discharge or Transfer with a revised date of 08/30/2025 documented, the facility should take appropriate steps to inform the resident where he or she is going and to ensure safe transportation. Additionally, if a resident is being transferred and return is expected, the following information should be conveyed to the receiving provider:Contact information of the provider responsible for care of the resident.Resident representative information.Advance Directive informationResident's care planOther information necessary to meet the resident's needs such as resident status, current mental, behavioral and functional status, reason for transfer and recent vital signs, diagnoses, allergies, medications including last received. Resident 2 admitted to the facility on [DATE] with diagnoses to include right cranioplasty (a neurosurgical procedure to repair a structural defect on the skull). The resident had a fall in January of 2026 which resulted in an acute subdural hematoma (a life-threatening medical emergency where blood pools between the brain and the skull's outer lining) that required a craniectomy (major neurosurgical procedure to permanently remove a section of the skull).Record review of Resident 2's progress note documented on 05/25/2026, the resident complained of shortness of breath, chest pain and left arm pain. The note indicated that the Licensed Nurse offered to call 911 and the resident refused and preferred to just walk over to the ER. The note did not indicate if a staff member walked with the resident or if they called the ER ahead of time to inform them that the resident was on their way.Record review of Resident 2's progress note documented on 05/28/2026, the resident informed the Licensed Nurse they were anxious and needs medication and wanted to go to the ER. The note indicated the resident walked to the ER. The note did not indicate if someone walked with the resident or if they called the ER ahead of time to inform them that the resident was on their way.Record review of Resident 2's progress notes documented on 05/30/2026, the resident complained about something wrong with their head and wanted to go to the ER. The Licensed Nurse documented Resident 2 walked to the ER. The note did not indicate if a staff member walked with the resident or if they called the ER to inform them that the resident was on their way.Review of Resident 2's activities of daily living care plan, with a print date of 06/03/2026 documented an intervention that the resident was able to walk in their room and the halls with distant supervision using a front-wheeled walker (FWW). This was dated 01/16/2026. There was no care plan of resident's ability to walk outside of the facility. Review of Resident 2's Kardex (reference tool on resident's medical status and daily routine) with a print date of 06/03/2026 documented that the resident was able to walk in room and halls with distant supervision using FWW. There were not mention about the resident's ability to walk outside of the facility. In an interview on 06/03/2026 at 1:50 PM, Resident 2 stated every time they had told staff they wanted to go to the ER they get scolded by the nurses, so they just walked to the ER on their own. In an interview on 06/03/2026 at 2:31 PM, Staff D, Licensed Practical Nurse (LPN) stated that when a resident requested to go to the ER, they usually asked why, assessed the resident then call 911 for transportation. Staff D stated they would not allow a resident to walk to the ER. They would call an ambulance to transfer them to the ER, send transfer forms, their face sheet, medication list and their Portable Orders for Life-Sustaining Treatment (POLST - a from designated a resident's code status and other treatment options) form with them.In an interview on 06/04/2026 at 9:49 AM, Staff E, LPN, stated they would not allow a resident to walk to the ER because of safety reasons.In an interview on 06/04/2026 at 11:05 AM, Staff C, LPN/Resident Care Manager stated when a resident insisted on walking to the ER, they would educate the resident about safety, called the ER to inform the resident was on their way, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	followed up to make sure the resident arrived to the ER safely, and then documented the information in the resident's progress note. Staff C added they would not allow a resident with chest pain to walk to the ER.In a joint interview with Staff A, Chief Executive Officer and Staff B, Registered Nurse/Chief Nursing Officer, on 06/04/2026 at 2:06 PM, Staff B, stated that a resident should not be walking on their own to the ER. Refer to WAC 388-97-1060(3)(g)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure pharmaceutical services which assured the accurate acquiring, dispensing, and administration of all drugs to meet the needs of each resident for 2 of 3 sampled residents (Residents 7 and 8) reviewed for medications. Failure to accurately transcribe physician's orders placed residents at risk for medication errors, medical complications, and unmet needs. Findings included. <RESIDENT 7>Resident 7 was admitted to the facility on [DATE] with a diagnosis to include Chronic Obstructive Pulmonary Disease (COPD - group of diseases that cause airflow blockage and breathing problems). Review of Resident 7's hospital discharge orders, dated 05/09/2026, documented an order for prednisone (a steroid that reduced inflammation, swelling, redness and allergic reactions) 20 milligram (mg) tablet. The order directed the nurse to administer 40 mgs by mouth [NAME]. Review of Resident 7's facility order summary report, dated 05/09/2026, documented an order for prednisone 20 mg tablet. The order directed the nurse to administer 20 mg by mouth daily. Review of a facility investigation, dated 05/13/2026, documented the prednisone order was transcribed incorrectly. Resident 7 received prednisone 20 mg for four days before the error was recognized. <RESIDENT 8>Resident 8 was admitted to the facility on [DATE]. Review of Resident 8's hospital discharge orders, dated 05/10/2026, documented an order for prednisolone acetate (a steroid that alleviated swelling, redness, and irritation in affected tissues) 1% eye drops place one drop in each eye four times a day. The resident was to receive atorvastatin (a medication to help lower cholesterol) 40 mg daily. Review of Resident 8's May 2026 Medication Administration Record (MAR), documented the atorvastatin and eye drops were not transcribed to the MAR. Review of a Facility investigation, dated 05/14/2026, documented Resident 8's atorvastatin and eye drops were not transcribed correctly to the MAR. The resident missed four days of receiving these medications. During an interview on 06/04/2026 at 2:21 PM, Staff B, Registered Nurse (RN)/Chief Nursing Officer, stated the expectation was two Licensed Nurses (LN) were to double check the hospital discharge orders and the facility admission orders to ensure medications were transcribed correctly. Staff B was aware this was not the first time in recent months the admission orders were not transcribed correctly to the facility admission orders and/or the MAR which resulted in medication errors. Refer to WAC 388-97-1300(1)(b)(i)(ii)