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	03/30/2026

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to review and revise care plans for 5 of 10 sampled residents (Resident's 4, 7, 8, 33 and 35) reviewed for care planning. These failures placed residents at risk for lack of consistent interventions, unmet care needs, adverse health effects, and a diminished quality of life.Findings included .<RESIDENT 4> Resident 4 was admitted on [DATE] with diagnoses to include routine healing of lumbar fracture, high blood pressure, and osteoporosis (disease that makes bones weak). Review of Resident 4's MORSE fall assessment, dated 03/05/2026, documented that they were a low fall risk upon admission. In a review of Resident 4's progress notes, on 03/14/2026 at 7:57 AM, Staff R, Registered Nurse (RN), documented that Resident 4 had a fall in the bathroom and 911 was called due to left hip pain. In a review of the incident report related to Resident 4's fall dated 03/14/2026 at 12:00 AM, Staff B, Director of Nursing (DNS)/RN, documented that Resident 4 was admitted to the hospital after the fall due to a left hip fracture requiring surgery. Resident 4 was planning to return to the facility after discharging from the hospital. Resident 4 readmitted to the facility on [DATE] with an updated MORSE fall assessment, dated 03/19/2026, documented that they were a high risk for falling. In a review of Resident 4's care plan dated, 03/12/2026, did not have documentation of the fall, after surgical interventions, or the updated high fall risk. In an interview on 03/26/2026, at 2:22 PM, Staff B, DNS/RN, confirmed that Resident 4's care plan was not updated with their high fall risk or surgical after care. Staff B stated the admission nurse who readmitted Resident 4 should have updated the care plan. <RESIDENT 7> Resident 7 admitted on [DATE] with diagnoses which included major depressive disorder, generalized anxiety disorder, bipolar disorder and post-traumatic stress disorder. Review of the trauma screening questionnaire completed on 02/23/2026 showed the resident experienced an extraordinarily stressful or event. (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 7's care plan, initiated on 02/24/2026, showed the resident was at risk for feelings of trauma or re-traumatization due to past trauma the resident experienced that includes diagnosis of PTSD. The care plan did not include individualized interventions to mitigate triggers. Review of a psychiatric consult on 03/09/2026 documented Resident 7 was hospitalized 30 years ago for a mental breakdown secondary to spousal abuse. In an interview and observation on 03/27/2026 at 9:20 AM Resident 7 stated they had been on psychotropic medications for a long time and they had PTSD. Resident 7 stated confrontations or loud voices trigger their PTSD. <RESIDENT 8> Resident 8 admitted on [DATE] with diagnoses to include brain, skin and liver cancer and drug induced constipation. Review of the significant change Minimum Data Set assessment on 02/13/2026 showed Resident 8 was on hospice with a life expectancy of less than six months and experienced constipation. Review of the care plan revised on 02/17/2026 failed to include the hospice provider, contact information and delineation of responsibilities between the facility and hospice provider. The care plan did not include constipation goals and interventions. The care plan only addressed monitoring for it in the pain care plan problem. In an interview and observation on 03/23/2026 at 9:50 AM, Resident 8 stated they were experiencing constipation and were miserable and thus was the first time dealing with terrible pain with constipation. Resident 8 said they had brain cancer and were on hospice. In an interview on 03/30/2026 at 12:10 PM, Staff B, Director of Nursing Services (DNS) stated they were unaware Resident 7 had PTSD and acknowledged triggers and interventions should be on the care plan. Staff B was unaware Resident 8 did not have a care plan addressing their constipation and hospice provider contact information and facility/ hospice provider responsibilities. Staff B commented care plans could be better managed. <RESIDENT 33> Resident 33 admitted to the facility on [DATE] with diagnoses to include acute posthemorrhagic anemia (a condition where a rapid, large volume of blood is lost), H. pylori infection (bacteria that infects the stomach lining), and an enlarged prostate. Resident 33's care plan, dated 02/14/2026, documented that they were a moderate fall risk, able to ambulate with one person assistance, requires one person assistance for dressing, bed mobility, eating, and toileting. In a review of Resident 33's progress notes, dated 03/14/2026 at 6:45 PM, Staff Q, Licensed Practical Nurse (LPN), documented that Resident 33 was found on the floor of the bathroom and was not transported to the hospital per evaluation from emergency medical services. In an observation on 03/23/2026, at 12:52 AM, Resident 33 was restless in bed, unable to answer (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	coherently and unable to follow direction to push the call light for help. In an interview on 03/23/2026, at 12:58 AM, Staff N, Certified Nursing Assistant(CNA)/Staffing Coordinator, went in to assist Resident 33. Staff N stated Resident 33 had been declining for approximately 10 days and is now requiring dependent care. In an interview on 03/30/2026, at 10:00 AM, Staff F, CNA, stated that Resident 33 was alert and orientated upon admission to the facility. Staff F stated that after the fall Resident 33 was having hallucinations and that is when they started to decline and needing more dependent care. In an interview on 03/26/2026, at 12:35 PM, Staff D LPN/Resident Care Manager, stated that they knew Resident 33 had declined quickly. Staff D confirmed the care plan was not updated to reflect Resident 33's change in care needs. In an interview on 03/26/2026, at 4:11 PM, Staff B, DNS/RN, stated that Resident 33's care plan was not updated timely. Staff B stated that that physical therapy department should be updating resident's needs in activities of daily living such as transferring, positioning, etc. and that nursing should be updating resident care needs. <RESIDENT 35> Resident 35 admitted to the facility on [DATE]. Review of Resident 35's admission Care Area Assessment (CAA-a tool used to create care plans), dated 12/08/2026, documented they had no teeth and had only dentures. In a review of Resident 35's care plan dated 12/08/2025 documented they had dentures, required assistance with denture care and directed staff to remove dentures at night to soak. Review of Resident 35's dental hygienist note, dated 01/07/2026, documented they had implants and the tissue around the implants were reddened and edema was present. Resident 35 was documented to decline cleaning. The dental hygienist recommended to remind Resident 35 to brush her implants. In an interview on 03/30/2026 at 9:41 AM Staff F, Nursing Assistant Certified, stated they were familiar with Resident 35. Staff F stated Resident 35 had dentures and was offered to have them removed and cleaned. Staff F stated sometimes Resident 35 declines. Staff F stated they know how to care for Resident 35 by reviewing their care plan and through report given by other staff. Staff F stated they were unaware Resident 35 had dental implants. Reference WAC 388-97-1020(5)(b)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interview, and record review, the facility failed to provide sufficient qualified staff to provide care and services for 7 of 12 sampled residents (Residents 7,8,18,24,33,44 and 52), that had concerns related to staffing on 2 of 2 halls (Portage and Ship Harbor). The facility had insufficient staff to ensure residents received prompt call light response, medications delivered timely, assistance with activities of daily living including nail care, restorative care, and meal assistance and to ensure care was completed in accordance with established clinical standards, the facility assessment, and resident's needs and preferences. These failures placed residents at risk of experiencing feelings of frustration, vulnerability, diminished quality of life, and unmet care needs.Findings included . <FACILITY ASSESSMENT>Review of the facility's assessment, reviewed 03/24/2026, showed the average daily census was 35.53 and the facility averaged one to three admits and one to two discharges daily. The assessment showed the Director of Nursing Services determined the staff to resident ratios based on acuity of the residents in each hall and skills and training of nursing staff. The DNS was responsible for adjusting staffing schedules as needed in care of call off for illness. The staff plan showed there were 2 nurses on days, 2 nurses in the evenings and one nurse on the night shift to care for an average of 35 residents. <MATRIX>Review of the facility's matrix, dated 03/23/2026, showed the facility admitted 19 residents in the past 30 days. <STAFFING PATTERN>Review of the facility provided staffing pattern for the last 31 days, dated 02/22/2026 through 03/23/2026, showed that 4 of the 31 days did not have the required 16 hours of RN coverage and 12 of the 31 days did not have 24-hour Registered Nurse (RN) coverage in the facility. <RESIDENT INTERVIEWS><RESIDENT 52>In an interview on 03/23/2026 at 9:28 AM, Resident 18 said the facility did not have enough staff. They stated they call for help and wait. The residents stated they wish they had more staff on the floor.<RESIDENT 7>In an interview on 03/23/2026 at 11:54 AM, Resident 7 stated the facility needed staffing help. The resident stated they had waited 45 minutes to get help to go to the bathroom. The resident stated when they complained to staff, the staff told them that it wasn't too long. The resident said they knew it was 45 minutes because they were watching the clock across from their bed. They stated they had to go to the bathroom so bad. The resident stated there were a few other times they waited almost 45 minutes. Resident 7 also stated they had only received warm meals on two days; other meals are delivered cold. <RESIDENT 33>In an interview on 03/23/2026 at 2:17 PM, Resident 33 stated call light wait times were grim here. The resident stated the facility was short staffed and staff were exhausted. The resident stated their care was not personalized. <RESIDENT 24>In an interview on 03/23/2026 at 3:15 PM, Resident 24 stated the facility seemed to be short staffed. The resident stated they were told three staff members called in sick over the weekend. <RESIDENT 44>In an interview on 03/23/2026 at 3:16 PM, Resident 44 stated the facility was short staffed. The resident said they waited up to an hour for staff to answer their call light. <RESTORATIVE CARE><RESIDENT 8>Review of Resident 8's physician order directed staff to complete the resident's restorative walking program 6 days a week.Review of restorative care documentation for Resident 8 showed they received their restorative program 5 of 31 days in January and 5 of 17 days in February. <RESIDENT COUNCIL MINUTES>-Review of the resident council minutes, dated 11/25/2025, residents voiced they wanted faster call light response times and for the aides to be more patient with them.-Review of the resident council minutes, dated 12/30/2025, residents voiced that staff never seem to have time when they need them and tell them they are too busy.- Review of the resident council minutes, dated 01/27/2026, residents were asked what staff can do to be more helpful with their stay. Residents responded they would like quicker call light response time.-Review of the resident council minutes, dated 02/24/2026, showed the residents voiced the staff needed to make sure call lights were in reach at all times. <RESIDENT COUNCIL MEETING>During a resident council meeting with the (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	surveyor on 03/25/2026 at 10:23 AM, Resident 18 stated call lights were being answered timely since state has been here. The resident stated they have waited hours and hours to get help and staff just let the call light go off. <STAFF INTERVIEWS>In an interview on 03/23/2026 at 11:36 AM, Staff N, Staffing Coordinator, said nursing assistants often worked double shifts. Staff N stated the facility needed two full time AM and two full time PM shift NAC's and another nurse.In an interview on 03/26/2026 at 2:52 PM, Staff I, Licensed Practical Nurse, said there were only two nurses on AM and PM shift then one on night shift. Staff I stated at least one day a week they are floundering. Staff I stated they were responsible for passing medications to an average of 20 residents, and last week they had 23 residents to pass medications to. Staff I stated residents have complained about cold meals for the past year. Staff I stated d last week breakfast trays were delivered at 7:45 AM and they were still giving care, so trays were not passed. Sometimes breakfast trays are delivered at 9 am and lunch can be anytime between 12 and 1 PM She said this is an ongoing frustrating issue that there is no consistency with mealtimes. They stated the wide range of meal deliveries makes it hard to give meds before meals, during or after per resident preference when they do not know what time the meals are coming.In an interview on 03/30/2026 at 12:10 PM, Staff B, Director of Nursing Services stated they currently needed to hire two AM shift aides and one PM shift aide and they may need another nurse next month. Staff B stated they were concerned that the new company told them to cut staffing and for the Per Patient Day (PPD) to go from their current 4.2 down to 3.38. Staff B stated the facility was very busy with 30-35 admits and discharges a month. They stated they have a very high acuity and cannot lower their staffing from what it is. Staff B stated the nursing staff were spread thin. They had hoped staffing would increase with the new company. Staff B stated they were aware of identified complaints that meals trays were delivered late, nail care was not provided, meds were administered late and two person transfers were being completed with only one staff present. Staff B stated restorative gets pulled to the floor often because they cannot find agency to cover shifts. Staff B stated they were aware they needed more oversight in the facility.In an interview on 03/30/2026 at 1:53 PM, Staff A, Administrator stated maybe the staff needed more training. Staff A stated the staff can grab them of Staff N for two person transfers. Staff A stated they had talked to the staff on how to plan their day. Staff A stated the facility had enough staff and they just needed them to do what they were supposed to do. They stated maybe the staff were not effective enough and they needed to do more training and have more accountability. Staff A stated the floor staff and shower aide should help with meals. Refer to WAC 388-97-1080 (1) .

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 the Dietary Manager, (Staff P), had proper qualifications. This failure placed residents at risk of receiving dietary services from staff without the required competencies and skills to carry out food and nutrition services.Findings included .Review of the facility provided position description for Dietary Manager (DM), undated, showed staff were to have one or more of the following required:Must have successful completion of a Dietary Manager's course from a vocational or community collegeMust have and maintain a Certified Dietary Manager's license, with associated continuing educationIn an interview on 03/23/2026 at 09:15 AM, Staff P stated they had been the Dietary Manager since December 2025. Staff P stated they were enrolled in the Dietary Manager course in February 2026 and have not completed it.In an interview on 03/30/2026 at 11:34 AM, Staff A, Administrator confirmed they were aware Staff P had not completed the Dietary Manager course.Reference WAC: 388-97-1160(2)(3)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 preplanned menus were followed. Failure to follow the preplanned menus altered the nutritional content of the diet and placed residents at risk for malnutrition and weight loss.Findings included .On 03/23/2026 Staff P, Dietary Manager (DM), provided 2 weeks of menus that were requested.Review of the weekly menu documented on 03/26/2026 the lunch meal would consist of cream of tomato soup, pepper steak, delicious rice, steamed vegetables, baked roll and peach marshmallow jello salad.In an interview on 03/26/2026 at 11:46 AM, Staff P, DM, stated they have been pretty good about sticking to the menu. Staff P stated if there was a change to the menu, they do not inform facility staff, they would update the menu outside of the dining room.In an observation on 03/26/2026 at 12:06 PM, Staff T, Cook, stated the prepared peach marshmallow jello salad was outside of the safe zone. Desserts were then placed in an ice bath (ice and water) to adjust the temperature.In an observation on 03/26/2026 at 12:21 PM, Staff T, Cook, rechecked the temperature of the peach marshmallow jello salad and it was not in the safe zone.In an observation on 03/26/2026 at 12:23, Staff T, Cook, stated they would not be able to serve the peach marshmallow jello salad to residents, and it was decided they would serve yogurt in place of the scheduled dessert.In an observation on 03/26/2026 at 12:54 PM, Staff N, NAC, stated a resident had asked about a roll that was on the menu for today's lunch meal. Staff T, cook stated they did not know if there was a change to the menu.In an observation on 03/26/2026 at 1:00 PM, the daily menu outside of the dining room showed the daily menu. There was no baked roll included in the daily menu. Staff N came back and stated they reviewed the resident's menu and there had been a baked roll for the lunch meal. No alternative for the baked roll was offered to the residents.Reference WAC: 388-97-1160(1)(a)(b)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide appetizing, palatable, and warm food for 7 of 7 residents (2, 7, 9, 18, 24, 26, and 27) reviewed for dining. This failure placed the residents at risk of a diminished dining experience and less than adequate nutritional intake, potentially leading to weight loss, dissatisfaction with meals and a decreased quality of life.Findings included .<RESIDENT COUNCIL MINUTES> Review of the 09/23/2025 resident council minutes showed residents stated sauces need more flavor, mac and cheese sauce were no longer good. They wanted more fresh fruit and vegetables. Residents said when they complete menu forms, their selections were not fulfilled or followed. Review of the 10/25/2025 resident council minutes showed the residents were asked about the menu. Residents stated it was easier to give up at this point. They stated they would like hot food and more vegetables. Review of the 11/25/2025 resident council minutes showed the residents stated they were served too much chicken and the desserts need work. Review of the 12/30/2025 resident council minutes showed the residents would like more green salads, diabetic friendly desserts and more of a variety of desserts. Review of the 01/27/2026 resident council minutes showed the residents again stated they were served too much chicken and they would like more variety of desserts. Review of the 02/24/2026 resident council minutes showed the residents again stated they were served too much chicken. <RESIDENT COUNCIL MEETING> In a Resident Council group interview on 03/25/2026 at 10:15 AM: - Resident 26 stated Don't ask me about the food. By the time it gets to me I do not expect it to be hot. - Resident 24 stated they were the last one at the end of the hall to get food and the food basically comes very cold. The resident stated they complained so much about the cold food, the staff now microwave theirs. -Resident 2 stated their chicken was cold yesterday. -Resident 18 stated their food is never delivered hot and staff do not offer to reheat their food. The resident stated if they had asked for their meal to be reheated, they are told the aides cannot run back and forth. In an interview on 03/26/2026 at 2:52 PM, Staff I, Licensed Practical Nurse stated residents complained of cold meals. Staff I stated this had been an issue for the past year. They stated last week breakfast trays were delivered at 7:45 AM and the staff were still giving care, so trays were not (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	passed. Staff I stated sometimes breakfast trays were delivered at 9 am and lunch can be anytime between 12 and 1 PM. Staff I said this was an ongoing frustrating issue that there was no consistency with meal times. In a phone interview on 03/27/2026 at 1:50 PM, Collateral Contact 1 (CC 1) Registered Dietician stated cold food had been the biggest complaint from the residents. CC 1 stated then they arrive at the facility at 9 AM the residents complain about the cold food. The residents say there is room for improvement in the food quality, temperature being cold and food being overcooked. In an interview on 03/30/2026 at 9:46 AM, Staff F, NAC stated residents complained of cold food. Staff F stated if they knew the resident is picky, they would try to hand deliver those trays first. They stated that sometimes trays are delivered at 7:30 AM and they are still getting residents up. They stated some kitchen staff are slow, and they get the trays at 8:30 AM. In an interview on 03/30/2026 at 11:21 AM, Staff E, Infection Preventionist stated the residents complained about cold food. Staff E stated they did not know what the root cause of the cold food was. In an interview on 03/30/2026 at 12:08 PM, Staff B, DNS stated the cold food issue should resolve when the elevator gets fixed and they can use the hot plates from downstairs to keep meals warm. <RESIDENT INTERVIEWS> <RESIDENT 4> In an interview on 03/23/2026, at 11:40 AM, Resident 4 stated that food that is supposed to be hot is served cold. In an interview on 03/26/2026, at 9:36 AM, Resident 4 stated that breakfast was served cold, which included cold scrambled eggs that they did not eat. In an interview on 03/27/2026, at 9:16 AM, Resident 4 stated that breakfast was served cold again, eggs are always cold and that the waffles were not good. <RESIDENT 7> In an interview on 03/23/2026 at 11:54 AM, Resident 7 stated the food sucks, I got warm meals delivered for 2 days otherwise all my food has been delivered cold. My old roommate's husband was bringing us meals three times a day since our food was cold. We do not get a lot of fresh fruit and vegetables. In an interview and observation on 03/24/2026 at 2:16 PM, Resident 7 was on the phone ordering a pizza.They stated lunch was too spicy and too dry, so they had to order a pizza. In an interview on 03/25/2026 at 11:29 AM, Resident 7 stated they did not eat their eggs this morning, only their bagel and fruit. The resident stated they did not eat the eggs because they were not solid. The resident stated the food had been delivered warmer since state was here, but it will go back to cold when we leave. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/26/2026 at 9:00 AM, Resident 7 stated they were served room [ROOM NUMBER]-1's tray and they ate some of their food before reading the meal slip. Resident 7 stated their eggs were lukewarm, they served toast but no butter. In an interview on 03/27/2026 at 9:20 AM, Resident 7 stated their breakfast was cold. They stated they were served cold waffles and would never eat the eggs because they were unrecognizable. The resident looked at the menu for lunch and said they would not eat that. Resident 7 stated they needed the alternate list so they could order what they wanted for lunch. <RESIDENT 9> In an interview and observation on 03/24/2026 at 09:31 AM Resident 9 stated they received cold cereal and scrambled eggs for breakfast. Resident 9 stated they do not like cold cereal and would prefer to have eggs, sausage or bacon and toast. Resident 9 stated they did not think there was an option to request their preferences for meals. In an observation and interview on 03/26/2026 at 08:51 AM, Resident 9 stated that their tray had toast that was cut into pieces and they did not like their toast cut into pieces. Resident breakfast tray was in front of them, and toast was observed to be cut into small square pieces and uneaten. In an interview on 03/27/2026 at 10:01 AM, Resident 9 stated they had a waffle and eggs that were cold. <RESIDENT 24> In an interview on 03/23/2026 at 3:15 PM, Resident 24 stated the food was always cold and feels they are the last residents to get their meals. <RESIDENT 27> In an observation on 03/25/2026 at 9:12 AM, Resident 27 was observed to request a banana and peanut butter, and they stated they had a terrible breakfast. Resident 27 admitted to the facility on [DATE] with diagnosis to include pressure ulcers. In an interview on 03/23/2026 at 2:41 PM Resident 27 stated the food at the facility was poor. Resident 27 stated they wrote down what had been served to them since admission and the food is awful. Resident 27 stated they continue to provide rice and green beans despite their preference for something different. In an interview and observation on 03/24/2026 at 1:02 PM Resident 27 was sitting on the edge of their bed, their overbed table in front of them, their lunch meal on a tray on the overbed table. Resident 27 stated the lunch served was not good. Observed Resident 27's platet which contained uneaten rice and salsa. Resident 27 stated the meal was not warm, the apple dessert wasn't good and the rest would be going back. Review of Resident 27's food preferences dated 03/06/2026, completed by the dietary manager, documented resident disliked green beans and apples. Reference: (WAC) 388-97-1100 (1), (2)

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	03/30/2026

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

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on observation and interview, the facility failed to consistently serve meals within the posted timeframe's and had longer than a 14 hour wait between when dinner and breakfast were served for 2 of 2 hallways. Failure to serve nourishing snacks to 5 of 7 residents (2, 12, 18, 24 and 26) and meals in a timely manner placed residents at risk of nutritional concerns, food temperatures served outside the desired temperature range, and a decreased quality of life.Findings included .<RESIDENT COUNCIL> In resident council group meeting on 03/25/2026 at 10:24 AM, Residents were asked if they received snacks at night. Residents 2, 12, 18, 24 and 26 stated they were not aware of possible snacks at night, and staff did not offer them. In an interview on 03/30/2026 at 12:08 PM, Staff B, DNS was informed resident council stated they were unaware about HS snack availability and that Ship Harbor got their trays at 8:53 AM when tray line was at 7:15 AM. Staff B was unaware of these concerns. No additional information was provided. On 03/23/2026 at 09:22 AM, Staff A stated mealtimes were 7:30 AM-8:00 AM for breakfast, 12:00 PM to 1:00 PM for lunch and dinner was scheduled for 5:00 PM to 6:00 PM. In an interview on 03/23/2026 at 09:15 AM, Staff P, Dietary Manager (DM) stated the mealtimes expectations were to serve breakfast from 7:15 AM to 8:15 AM, lunch from 12:00 PM to 1:00 PM and dinner from 5:00 PM to 6:00 PM. In an interview on 03/26/2026 at 11:23 AM, Staff P, DM, stated they were unaware breakfast trays were not delivered to some residents until 8:45 AM or later. Staff P stated kitchen staffing was stretched thin, and they tried to schedule increased staff in the mornings. In an observation and interview on 03/24/2026 at 08:44 AM, observed breakfast meal cart for room trays still parked on the Portage hallway. Staff I, Licensed Practical Nurse, (LPN), verified the meal cart with breakfast trays had not made it to the Ships Harbor hallway yet and stated it could take until 09:00 AM. In an observation on 03/26/2026 at 08:20 AM, the breakfast meal cart with hall trays was observed to be on the Portage hallway with trays still being served. In an interview on 03/26/2026 at 08:26 AM, Staff F, Nursing Aide Certified (NAC), confirmed the breakfast meal cart had not been delivered to Ships Harbor hallway. In an observation on 03/26/2026 at 08:45 AM, the breakfast meal cart was observed on the Ships Harbor hallway and trays were being delivered to resident rooms. Reference WAC: 388-97-1160(1)(a)(b)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews, the facility failed to ensure resident meals were prepared and stored in accordance with professional standards of food safety 1 of 1nourishment refrigerators. The failure to ensure the nourishment refrigerator were free from potential contaminants, maintenance to ensure the nourishment refrigerator and freezer were properly maintained left residents at risk for food contamination, food borne illnesses, and spoiled food. Findings Included .In an observation on 03/23/2026 at 12:19 PM the nourishment refrigerator and freezer had multiple items in it opened, undated and expired food items. Observed a sign on the refrigerator that read the refrigerator/freezer were used for patient snacks and supplements and any non-labeled items would be discarded, signed by the dietary manager. The following items were located within the refrigerator:- A sandwich covered with foil with the room [ROOM NUMBER]-2 on it, not dated. -A peach cobbler dated 3/20 with room [ROOM NUMBER]-2 -A hardboiled egg, undated, in a plastic cup with a cover. -Peanut Butter and Jelly dated 3/17-A cheese and meat sandwich dated 3/20 use by 3/17-Fried chicken labeled for staff packed on 3/18 with a sell by date of 3/19-Noodle soup in container inside a plastic bag with room [ROOM NUMBER]-1, undated.-Cheeseburgers sliders and half eaten salad labeled room [ROOM NUMBER]-1, undated. -A paper bag with two mushy eggs dated 3/19-Quarter gallon of milk with expiration date of 03/18/2026-Half and half with expiration 2/8/2026 labeled room [ROOM NUMBER]-2 -Moldy cheese in plastic container, undated, labeled room [ROOM NUMBER]-16 -Allen's cheese 16-1 2/23/2026 trash in it -Fast food bag with food in it, undated, labeled room [ROOM NUMBER]-2-Brown paper bag labeled with Staff L, Nursing Assistant Certified, name, contained half eaten burrito, undated. -Opened half empty 20-ounce sprite, undated-grapes, undated-Opened melon and pineapple tray, dated it was packaged on 3/17/2026 with a sell through date of 3/20/2026.-Container of carrots and rice/chicken, undated-Plastic cup with light golden-brown color food item with liquid on the top and solids on the bottom, undated dated. -Bag full of sodas and glass jars filled with pickled herring rolled in disposable chuck pads with undated and unnamed. -Asian spice sauce in jar in fridge door, no date. -Wild sockeye salmon, 16-2 undatedThe refrigerator bottom drawer was empty, dirty with debris and yellow spill marks. The following items were located in the freezer:-grocery store plastic bag frozen to door storage, undated and no name. Unable to see the contents.-banana frozen in bag no date, unlabeled -undated chimichangas On 03/23/2026 at 12:30 PM located the temperature log for the nourishment refrigerator, in a drawer next to the refrigerator, dated July 2025, with multiple missing entries. No other temperature logs were located or provided. In an interview on 03/23/2026 3:30 PM Staff L, NAC, stated they were leaving with their paper bag and burrito from yesterday's lunch from the nourishment refrigerator. When asked where their lunch should be kept, Staff L stated they did not know and they had only worked at the facility for three weeks and was still learning. In an interview on 03/26/2026 at 11:20 AM, Staff P, Dietary Manager stated they and the dietary staff were not responsible for checking the temperature in the nourishment refrigerator. Staff P stated nursing staff were responsible for the maintenance and logging of temperatures of the nourishment refrigerator. In an interview on 03/30/2026 11:16 AM Staff E Infection Control/Registered Nurse stated the nourishment refrigerator temperatures and oversight were completed by the nurses on overnight shift. Reference WAC 388-97-1100(3)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 were compliant with Infection Prevention and and Control Guidelines and standards of practice for 2 of 2 hallways (Portage Hall and Ship Harbor Hall) reviewed for Contact Precautions (infection control measures used to prevent the spread of germs through direct or indirect contact by wearing a gown and gloves before entering the resident room) for residents (Resident 20, 33, and 49) and ensure appropriate disinfection of blood glucose meters (device used to measure blood glucose levels) between each resident use. The facility failed to ensure staff were compliant with appropriate hand hygiene practices during wound care for 1 of 1 residents (Resident 28). These failures placed all residents and staff at risk of potential infection. Findings included .According to the Centers for Disease Control (CDC) titled, Transmission-Based Precautions, dated 04/03/2024, Contact Precautions are used for patients with known or suspected infections that represent an increased risk for contact transmission. Contact Precaution patients should be placed in a single patient room or make room placement decisions balancing risks to other patients. Contact Precautions require using personal protective equipment (PPE) appropriately, which included putting on gown and gloves upon room entry. According to the CDC titled, Implementation of Personal Protective Equipment Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), dated 04/02/2024, Enhanced Barrier Precautions (EBP) may be indicated when Contact Precautions do not otherwise apply for residents with the following: indwelling medical devices (such as a catheter, a tube that goes into the bladder to drain urine), regardless of MDRO colonization or infection or colonization with an MDRO. EBP require staff to wear a gown and gloves only during high contact resident care activities. <CONTACT PRECAUTIONS> <RESIDENT 20> Resident 20 was admitted to the facility on [DATE] with diagnoses to include an indwelling catheter related to obstructive uropathy and an enlarged prostate (a blockage in the urinary tract that prevents normal urine flow) and a urinary tract infection (UTI) with Methicillin-resistant Staphylococcus aureus (MRSA) a type of MDRO. During an observation on 03/23/2026, at 9:30 AM, Resident 20 had a Contact Precautions sign posted outside of their door with a note on it that said Bed #1. Resident 20 had a roommate who was not on Contact Precautions. The Contact Precautions sign stated to wear gown and gloves when entering the room. Review of resident 20's care plan, dated 02/23/2026, documented that Resident 20 had a UTI with MRSA and was on Contact Precautions. The care plan also documented that staff would follow the Contact Precautions on the sign posted outside the room. In an interview on 03/23/2026, at 9:31 AM, Staff G, Certified Nursing Assistant (CNA), stated that Resident 20 was on Contact Precautions because they have a catheter. In an observation on 03/23/2026, at 10:11 AM, Staff F, CNA, went into Resident 20's room without gown or gloves on and Contact Precautions sign posted outside of the door. In an observation on 03/23/2026, at 10:12 AM, Staff G, CNA, went into Resident 20's room without gown or gloves on and Contact Precautions sign posted outside of the door. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a joint observation and interview on 03/24/2026, Staff U, CNA, went into Resident 20's room without gown or gloves on and Contact Precautions sign posted outside of the door. When Staff U exited the room, they stated that they should have worn gown and gloves when assisting bed one. <BLOOD GLUCOSE METERS> In a joint observation and interview of Portage Hall Medication cart on 03/26/2026, at 10:13 AM, blood glucose monitors were observed to be in individual pouches for each resident that required one with diabetic strips, lancets, and alcohol prep pads. Staff K, Licensed Practical Nurse (LPN), stated that diabetic supplies are individual for each resident, they are to be cleaned after each use with an alcohol prep pad. In review of the Assure Prism User Instruction Manual, documented that the blood glucose meters should be cleaned and disinfected after use on each patient. The user manual stated that they have validated Clorox Healthcare Bleach Germicidal Wipes, Dispatch Hospital Cleaner Disinfectant Towels with Bleach, CaviWipes1, and PDI Super Sani-Cloth Germicidal Disposable Wipe for disinfecting the Assure Prism multi meter. In an interview on 03/26/2026, at 11:37 AM, Staff E, IP/RN, stated that each reach resident has their own blood glucose monitor but it should be disinfected between each use with the purple top wipes (Super Sani-Cloth Germicidal Disposable Wipe). In an interview on 03/26/2026, at 3:55 PM, Staff B, Director of Nursing (DNS)/RN, stated that their expectation of disinfection for the blood glucose glucometers would be to clean after every use with the purple top wipes (Super Sani-Cloth Germicidal Disposable Wipe). <RESIDENT 33> Resident 33 admitted to the facility on [DATE] with diagnoses to included indwelling catheter. Resident 33 was diagnosed with a urinary tract infection (UTI), 03/09/2026, with Extended-Spectrum Beta-Lactamases (ESBL - a type of MDRO). During an observation on 03/23/2026, at 9:30 AM, Resident 33 had a Contact Precautions sign posted outside of their door with a note on it that said Bed #1. Resident 33 had a roommate who was not on Contact Precautions but was on Enhanced Barrier Precautions. Review of Resident 33's care plan, dated 02/14/2026, documented that Resident 33 is on Contact Precautions due to the ESBL UTI. The care plan documented that staff will wear appropriate PPE when caring for resident. In an observation on 03/23/2026, at 12:30 PM, Staff N, CNA/Staff Coordinator, went into Resident 33's room without gown or gloves on and Contact Precautions posted outside of the door. The Contact Precautions sign stated to wear gown and gloves when entering the room. In an interview on 03/25/2026, at 3:15 PM, Staff E, Infection Preventionist (IP)/Registered Nurse (RN), stated that if a resident on Contact Precautions is sharing a room then the staff only need to gown and glove for the resident with the precautions. Staff E also stated residents on Contact Precautions should be isolated to their rooms as much as possible. Staff E stated that residents on Contact Precautions would be in private rooms in available or would try to room them with other (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Contact Precaution residents with similar infections if possible. In an interview on 03/27/2026, at 2:33 PM, Staff B, DNS/RN, stated that they decide as a team which precautions resident's should be. Requested any documentation that would justify that the resident's needed to be on Contact Precautions versus Enhanced Barrier Precautions. No further information was provided. <RESIDENT 49> In an observation and interview on 03/23/2026 at 2:26 PM, Staff O, Licensed Practical Nurse (LPN), was observed to be in Resident 49's room with no PPE. Observed signage outside of Resident 49's room indicated transmission-based precautions (TBP) and what specific PPE to be worn. Staff O, LPN, was observed to come out of Resident 49's room, when asked about the TBP signage, they stated they did not require any PPE since they did not provide care to the resident. In an observation and interview on 03/25/2026 at 08:46 AM, Staff W, Nursing Assistant Certified (NAC) was observed to enter Resident 49's room without putting on PPE or hand hygiene. Staff W, NAC, was observed to remove Resident 49's breakfast tray and put it in the meal cart. Staff W stated they should have performed hand hygiene before entering the room. Staff W, NAC, confirmed the TBP signage instructed staff to wear gloves and a gown to enter the room. Staff W, NAC, stated they were unsure if they required PPE if they did not provide care to the resident. In an interview on 03/24/2026 at 09:45, Staff E, Infection Preventionist/Registered Nurse (IP/RN), stated their expectation was for staff to follow TBP signage. Staff E, IP/RN, stated staff should have worn gloves and a gown to enter Resident 49's room. In an observation on 03/30/2026 at 11:33 AM, Resident 28 was positioned on their back then positioned on their right side. Staff C, Registered Nurse (RN) removed a dressing that had feces on it. Staff C proceeded to apply cream with a cotton swab and place a clean foam dressing without removing gloves or performing hand hygiene. In an interview on 03/30/2026 at 11:59 AM, Staff B Director of Nursing Services stated Staff C, RN should have completed hand hygiene and put new gloves on in between soiled dressing removal and application of the clean dressing. Reference WAC: 388-97-1320 (1)(C)(2)(C)(5)(C)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility failed to maintain a resident call light system that was functionable and audible, as required in 2 of 2 halls (Portage Hall and Ships Harbor Hall). This failure placed all facility residents at risk of potentially avoidable accidents, unmet care needs, and diminished quality of life. Findings included .<SHIPS HARBOR HALL> In an observation on 03/23/2026 at 12:49 PM room [ROOM NUMBER] call light was on, visible, not audible. In an observation on 03/24/2026 at 12:48 PM room [ROOM NUMBER]'s call light was on, visible, not audible. In an observation on 03/25/2026 at 9:27 AM room [ROOM NUMBER]'s call light was on, visible, not audible. In an observation on 03/23/2026 at 10:28 AM, the call light was on for room [ROOM NUMBER]-1 but it was not audible. In an observation on 03/23/2026 at 11:50 AM, the call light was on for room [ROOM NUMBER] but it was not audible. In an observation on 03/23/2026 at 2:59 PM, the call lights were on for room's 1 and 3 but they were not audible. In an observation on 03/25/2026 at 1:16 PM the call light for room [ROOM NUMBER] light was on but not audible. In an observation and interview on 03/26/2026 at 9:23 AM, the call light for room [ROOM NUMBER] was on but not audible. Staff F, Nurse's Aide Certified (NAC) stated the volume must have been turned down but if you listen closely and it is quiet, you can hear it. In an interview on 03/26/2026 at 10:16 AM, Staff N, Staffing Coordinator stated the call light sound has been very light but if they listen closely, they can hear them. Staff N could not say how long the call lights were turned down. In an observation on 03/27/2026 at 12:18 PM, the call light was on for room [ROOM NUMBER] and faintly audible at nurses' station at the computer but not audible in the halls. In an observation on 03/27/2026 at 3:11 PM, the call light for room [ROOM NUMBER] was light on. Staff _maintenance was moving wires by the call light monitor computer screen. The sound was audible only when at the monitor. In a follow up interview on 03/30/2026 9:46 AM, Staff F, NAC stated call light volumes were turned down on night shifts. Staff E stated the night shift tells them they turn the volume down because the residents could hear it. Staff F stated when they come in at 6 AM, the call lights were turned down. Staff F stated they hid the mouse from night shift and one of the Director of Nursing Services even locked the mouse up so night shift could not turn the volume down. Staff F stated this was an ongoing (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	issue. In an interview on 03/30/2026 at 11:18 AM Staff E, Infection Preventionist stated the call light volume is supposed to be up and audible, but the staff had access to change it. In an interview on 03/30/2026 at 12:47 PM, Staff A, Administrator stated they were aware the call light volume was being turned down and the expectation was that the call lights must be audible at all times. In an observation on 03/30/2026 at 4:02 PM, the call light volume was observed turned down on the call light monitor screen. <PORTAGE HALL> In an observation on 03/23/2026, at 10:33 AM, room eight had a red call light, indicating an emergency, lit above their door but not audible in the hallway. In an observation on 03/23/2026, at 12:14 PM, room six had their call light lit above their door but not audible in the hallway. In an observation on 03/24/2026, at 9:14 AM, room seven had their call light lit above their door but not audible in the hallway. In an observation on 03/25/2026, at 9:19 AM, room one had their call light lit above their door but not audible in the hallway. In an observation on 03/26/2026, at 11:37 AM, room five had a red call light lit above their door but not audible in the hallway. This is a repeat deficiency from 05/14/2025. Reference WAC 388-97-2280 (1)(a)(b)(c)(2)

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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 interview and record review the facility failed to ensure that each resident was treated with respect, dignity and failed to promote and protect the rights of each resident for three of three residents (27, 31, and 28) reviewed for dignity. This failure had the potential to result in embarrassment and psychological harm to Resident's when staff members failed to provide privacy during care.Findings included . Review of the undated facility policy Resident Rights showed employees shall treat resident's with kindness, respect, and dignity. Federal and state laws guarantee certain basic rights to all residents of the facility and include the right to a dignified existence, be free from abuse, participate in care planning and treatment, and be supported by the facility to exercise their rights. Review of the admission packet included an undated copy of Your Rights as a Resident showed residents have the right to choose their activities, schedules and health care they want. Residents have the right to plan aspects of their life in the facility taking into consideration those things that are significant and important to them. <RESIDENT 28> Resident 28 admitted to the facility on [DATE] with diagnoses to include cardiac disease and anxiety. Review of the annual Minimum Data Set (MDS), an assessment tool dated 01/13/2026 showed the resident had depression, anxiety and cognitive impairment. In an observation on 03/30/2026 at 11:33 AM until 11:42 AM, Staff C, Registered Nurse performed wound care to Resident 28. Resident 28 was positioned on their back. The privacy curtain was not pulled around the resident during the peri care or wound care. The curtain remained pulled halfway to the residents waist on both sides. The resident was exposed from their waist down. Resident 28's roommate was present in the room. In an interview on 03/30/2026 at 11:59 AM, Staff B, Director of Nursing was informed of the lack of privacy curtain for Resident 28 during observation of peri and wound care. Staff B stated the privacy curtain should be pulled around the resident during care. <RESIDENT 27> Resident 27 admitted to the facility on [DATE], with diagnoses to include pressure-induced deep tissue injury, surgical aftercare, anxiety and depression. In an observation on 03/25/2026 at 09:23 AM, Staff K, Licensed Practical Nurse, was observed to check Resident 27's wound dressing. Staff K closed the door to Resident 27's room and requested the resident to pull down his pants so that the wound dressing could be observed on his back side. Staff K did not pull the privacy curtain around to protect Resident 27's privacy. The full window blinds were open, and the view is of the facility parking lot. Resident 27 pulled pants down, Staff K assessed the wound dressing and left the room. In an interview on 03/25/2026 at 09:30 AM, Staff K stated they should have closed the blinds to (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	maintain Resident 27's privacy. <RESIDENT 31> Resident 31 was admitted to the facility on [DATE] with diagnoses to include chronic venous insufficiency (condition that damages leg veins and causes blood to pool in the legs), weakness, chronic pain and depression. In an observation on 03/23/2026 at 10:32 AM, Staff L, Nursing Assistant Certified (NAC), was observed to provide incontinence care for Resident 31. Staff L provided incontinence care with Resident 27's window blinds open and did not protect Resident 27's privacy. In an interview on 03/30/2026 at 11:34 AM, Staff B, Director of Nursing Services (DNS) stated their expectation was to provide privacy for resident's during care. Reference (WAC) 388-97-0180 (1-4)

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	03/30/2026

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observations and interviews, the facility failed to ensure a clean, safe, comfortable and homelike environment for 2 of 2 halls (Portage Hall and Ship Harbor Hall), 1 of 1 shower rooms and 1 of 1 resident rooms (room [ROOM NUMBER]) reviewed for restraints and securement of a cable box device, and 1 of 1 resident rooms (room [ROOM NUMBER]) reviewed for floorboards. Failure to maintain carpets, floorboards, shower rooms and bed rails and floorboards in good repair and safely functioning, and carpets and shower room in sanitary condition placed residents at risk for diminished quality of life and compromised dignity. Findings included .<SHOWER ROOM> On 03/25/2026 at 8:56 AM observed the shower room to have a bathroom to the left upon enter with a sign noting for staff use, a room which was tiled and had missing shower head and handle with various items stored and another room which contained the shower room. The storage room contained various items in the corner, piled high, hair washing blow up sink, bagged items, and shoes. In an interview on 03/30/2026 at 11:48 AM Staff B, Director of Nurses services, stated the items found in the shower room storage area were items stored by social services and needed to be removed. <BED RAILS> On 03/23/2026 at 12:06 PM observed room [ROOM NUMBER] window bed with bilateral half bed rails attached to their bed. When touched the left side bed rail was wobbly and not secured tightly. On 03/25/2026 9:09 AM observed bed rails in resident room. When touched the left side was not attached securely with movement back and forth. In an interview and observation on 03/30/2026 at 11:54 AM Staff M, Regional Maintenance Director, checked room [ROOM NUMBER] windows bed half bed rails. Observed the right side of the bed to have a securely attached bed rail and the left side not securely attached. Staff K stated the bed rail on the left side needed to be tightened and was unaware of how it became loose as it was just checked as part of an audit. <CABLE BOX> On 03/23/2026 at 12:06 PM observed room [ROOM NUMBER]'s, bed closest to the door, had a television mounted to the wall with a cable box hanging from the television by cords. In subsequent observations on 03/24/2026 12:31 PM and 03/25/2026 9:12 AM the cable box was hanging from the television by cords. In an interview on 03/30/2026 at 9:41 AM Staff O, NAC stated there were several rooms with cable boxes hanging by cords from televisions mounted on the wall. Staff NAC stated it looked tacky and they had not fallen yet. In an interview on 03/30/2026 at 12:42 PM Staff A, Administrator stated they had switched cable providers last year and had been working on securing the cable boxes. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<room [ROOM NUMBER]> On 03/24/2026 at 9:41 AM observed the floorboard molding, behind bed, peeling from the wall in room [ROOM NUMBER]. In an interview on 03/30/2026 at 12:42 PM Staff A, Administrator stated they were unaware of the floorboard molding pulling from the wall in room [ROOM NUMBER]. <SHIP HARBOR HALL> On 03/23/2026 at 12:58 PM observed several large red stains/markings on the hallway carpet. On 03/24/2026 at 8:50 AM observed large stains/markings on carpet outside of room [ROOM NUMBER] and across from room [ROOM NUMBER]. In a joint interview on 03/30/2026 at 12:42 PM Staff A, Administrator, and Staff B Director of Nursing Services stated they were in the process of replacing the carpet and measurements had already been taken. <PORTAGE HALLWAY> In an observation on 03/23/2026, at 12:15 PM, a red stain was on the carpet in front of room seven measuring approximately 12 inches long and six inches wide. In an observation on 03/23/2026, at 12:16 PM, a red stain was on the carpet in front of room one measuring approximately eight inches long and 12 inches wide. In an observation on 03/23/2026, at 12:17 PM, a dark brown/yellow stain was on the carpet in front of room [ROOM NUMBER] measuring approximately 12 inches long by four inches wide. In an observation on 03/24/2026, at 9:36 AM, a blue two-seater couch at the nurse's station looked worn with torn fabric. A gray one-seater chair also looked worn with torn fabric. WAC Reference 388-97-0880(1)(2)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the identification of verbal and mental abuse, and the protection of residents from their Alleged Perpetrator/Alleged Perpetrators (AP/APs), after allegations of abuse were reported to the facility for 1 of 1 residents (Resident 14) reviewed for abuse/neglect. This failure placed all residents at risk for further abuse, fear, and unmet care and services. Findings included .Review of the facility policy titled, Abuse, Neglect, Mistreatment and Misappropriation of Resident Property, dated as version 09/21/2022 documented the facility residents have the right to be free from abuse, neglect, and misappropriation of resident property, and exploitation to include verbal and mental abuse. The facility would not condone any form of resident abuse or neglect, protect residents from harm during investigations and screening and training employees.Resident 14 admitted to the facility on [DATE] with diagnoses to include fracture and urinary tract infection.Review of Resident 14's admission Minimum Data Set (an assessment tool) dated 03/17/2026 showed they were cognitively intact with a score of 13 out of 15 on their Brief Interview for Mental Status (BIMS).In an interview on 03/24/2026 at 9:48 AM Resident 14 stated the facility had to move them to a different room after their room mate was insulting them and their visitors, calling them stupid.Review of Resident 14's progress note dated 03/15/2026 documented they had a concern their roommate, Resident 35, was verbally abusive to their friends while visiting.Review of Resident 35's progress note dated 12/31/2025 documented their roommate stated they were verbally aggressive and rude to them; however the staff had not seen or heard the verbal aggression.Review of Resident 14's progress note dated 03/17/2026 documented they were unhappy with their roommate and was being moved to a different room, two days after their initial concern was reported to the nurse.In an interview on 03/25/2026 at 2:43 PM Staff K, Licensed Practical Nurse (LPN), stated they were familiar with Resident 35, they were aware of their behaviors which included yelling and cussing at people and thought they were told about an incident in which it was directed at their roommate from December 2025. Staff K stated Resident 35 could be verbally nasty, which was a form of verbal abuse. Staff K stated they could not recall all the details but would report the concerns to the Director of Nurses (DNS) and social services.In an interview on 03/25/2026 at 2:59 PM Staff A, Administrator stated Resident 14 had made a comment to the nurse that their roommate, Resident 35, was mean to their visitors. Staff A stated they did not know whether Resident 14 was interviewed or not about the incident.In an interview on 03/25/2026 at 4:44 PM Staff J Social Services Manager, stated they were made aware Resident 14 wanted to move rooms due to concerns with their roommate, Resident 35. Staff J stated they met with Resident 14 and asked them if they still wanted a room move and they confirmed they did and they were moved. Staff J stated they did not speak with Resident 14 about the issues surrounding the reason for wanting to move or any interactions between Resident 14 and Resident 35. Staff stated Resident 35 was confused, had cognitive impairment and often yelled out which caused difficulty for their roommates.In an interview on 03/30/2026 at 9:41 AM Staff F, NAC, stated they were a mandated reporter, and they were required to make a report to the state hotline, their nurse, and DNS. Staff F described Resident 35 as being more vocal at night per report from night shift. Staff F stated Resident 35 could become angry and verbally unfriendly to staff. Staff F stated they had not witnessed but was informed Resident 35 was not nice to a prior roommate, could not recall their name and was a couple months ago. Staff F described Resident 35 as being more lucid and nicer during the day and more confused at night.In an interview on 03/30/2026 at 10:17 AM Staff I, LPN, stated they were familiar with Resident 35 and had been informed, by other staff in report, they had been rude to a couple of roommates and families. When asked what was reported, Staff I stated Resident 35 had been belittling and degrading toward their roommates. Staff I stated belittling and degrading was a form of mental/verbal abuse. Staff I stated (continued on next page)

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	505216	A. Building B. Wing	03/30/2026

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility moved Resident 35's roommate to another room. Staff I stated they did not witness the interaction between Resident 35 and Resident 14 as it occurred when they were not there.Review of the incident report dated 03/25/2026, received on 03/31/2026, documented Resident 35 had a history of being verbally aggressive toward their roommate as of 12/31/2025, had an interaction with Resident 14 and their visitors on 03/15/2026, and a room move was complete on 3/17/2026. Resident 14 was interviewed on 03/25/2026 at which time they confirmed their roommate, Resident 35 was belligerent toward them and their visitors. There was no noted interviews with Resident 14 at the time of the incident or at the time of the room move.WAC Reference 388-97-0640(1)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a resident was not administered an antipsychotic (medication that affected the brain, emotions, or behaviors) unless the medication was necessary to treat a specific condition documented in the clinical record for 1 of 5 sampled residents (Resident 35), reviewed for unnecessary medications. This failure placed residents at risk of side-effects from the medications, unnecessary chemical restraints, and a diminished quality of life.Findings included .As referenced in the Food and Drugs/Drug (FDA) Safety Information, anti-psychotic medications have serious side effects and can be especially dangerous for elderly residents. The use of anti-psychotic medications without an adequate rationale, or for the sole purpose of limiting or controlling expressions or indications of distress without first identifying the cause, there was little chance that they would be effective, and they commonly cause complications such as movement disorders, falls with injury, stroke, and increased risk of death. The FDA Boxed Warning, which accompanied, second-generation anti-psychotics stated, Elderly patients with dementia-related psychosis treated with atypical anti-psychotic drugs are at an increased risk of death.Review of the facility policy titled, Medications, Psychotropics, undated documented the facility would gather behavioral information and history of a resident when they admitted with psychotropic medications. During their stay, the residents would be monitored, assessed for environmental triggers, pain, depression, infection or other illness as possible factors that impacted the resident's behavior/mood. Nonpharmacological methods for resident challenging behaviors would be utilized prior to the use of a psychotropic medication.Resident 35 admitted to the facility on [DATE] with diagnoses to include dementia with behaviors and major depressive disorder.Review of Resident 35's admission Minimum Data Set (MDS-an assessment tool) dated 12/08/2025 showed they were severely cognitively impaired with a score of 4 out of 15 on their Brief Interview for Mental Status (BIMS-cognitive assessment tool).Review of Resident 35's Care Area Assessment (CAA-tool to create a care plan) dated 12/10/2025 documented they prescribed Seroquel (an antipsychotic medication) to treat dementia with behaviors. Resident 35 was described as having confusion and forgetfulness in addition to treatment for a urinary tract infection.Review of Resident 35's care plan dated 12/02/2025 documented they used Seroquel to treat dementia with behaviors with the goal to be free of complications related to use. Interventions included monitoring target behaviors for the use of Seroquel; yelling/screaming at staff, hitting/grabbing staff, and increased confusion. There were no monitors personalized to Resident 35's to capture psychosis (thought and emotions that are so impaired that contact is lost with external reality).Review of Resident 35's pharmacy review dated 12/31/2025 documented a recommendation for the provider to review Seroquel use as they had been taking an as needed dose prior to admission to the facility.Review of behavior monitors for December 2025 documented Resident 35 had 6 instances of yelling/screaming at staff during day shift, 13 instances during evening shift, and 3 instances during night shift.Review of Resident 35's behavioral progress note dated 01/06/2026 documented they were pleasantly confused with a bright affect and fully engaged in conversation.Review of Resident 35's electronic health record documented no information regarding their behaviors prior to their admission to the facility.In an interview on 03/25/2026 at 4:44 PM Staff J, Social Services Manager, stated Resident 35 admitted to the facility from an assisted living facility. Staff J stated Resident 35 often believed they worked at the facility and yelled out.In an interview on 03/26/2026 at 3:25 PM Staff D stated when a resident was placed on psychotropic medication there were assessments completed by social services. Staff D stated antipsychotic medications were used to treat behaviors like hallucinations and dementia with behaviors.In an interview on 03/27/2026 at 10:25 AM Staff B, Director of Nursing Services, stated Resident 35 admitted with confusion and difficult behaviors, was sent to the emergency room, and found to have a urinary tract infection.Reference WAC 388-97-0620 (1)(a)(4)(a)

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	505216	A. Building B. Wing	03/30/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to ensure reporting of alleged verbal and mental abuse, resident to resident altercations, to the State Agency for 2 of 2 residents (Resident 14 and unidentified resident), reviewed for abuse/neglect reporting. This failure placed residents at risk for potential unidentified and ongoing abuse and lack of protection from abuse.Findings included .Review of the facility policy titled, Abuse, Neglect, Mistreatment and Misappropriation of Resident Property, dated as version 09/21/2022 documented the facility would report per the Nursing Home Guidelines, The Purple Book, facility staff were mandated reporters and thy would report to state agency if they had a reasonable cause to believe or suspect abuse occurred to a vulnerable adult.Review of the Nursing Home Guidelines, also known as the Purple Book, dated October 2015 showed the facility was to report to the state agency and one method of reporting was by the state reporting log. The incident was to be reported via the reporting log within 5 days of discovery.Review of Resident 14's progress note dated 03/15/2026 documented they had a concern their roommate, Resident 35, was verbally abusive to their friends while visiting.In an interview on 03/24/2026 at 9:48 AM Resident 14 stated the facility had to move them to a different room after their room mate was insulting them and their visitors, calling them stupid.Review of Resident 35's progress note dated 12/31/2025 documented their roommate (unidentified resident) documented they were verbally aggressive and rude to them; however, they had not seen or heard the verbal aggression.Review of the state reporting log from December 2025 through March 23, 2026 documented no instances of a resident-to-resident verbal altercations.In an interview on 03/30/2026 at 9:41 AM Staff F, Nursing Assistant Certified, stated they were a mandated reporter, and they were required to make a report to the state hotline, their nurse, and DNS. Staff F described Resident 35 as being more vocal at night per report from night shift. Staff F stated Resident 35 could become angry and verbally unfriendly to staff. Staff F stated they had not witnessed but was informed Resident 35 was not nice to a prior roommate, could not recall their name and occurred a couple months ago.In an interview on 03/30/2026 at 10:17 AM Staff I, Licensed Practical Nurse, stated they were familiar with Resident 35 and had been informed, by other staff in report, they had been rude to a couple of roommates and families. When asked what was reported, Staff I stated Resident 35 had been belittling and degrading toward their roommates. Staff I stated belittling and degrading was a form of mental/verbal abuse. Staff I stated the facility moved Resident 35's roommate to another room. Staff I stated they did not witness the interaction between Resident 35 and Resident 14 as it occurred when they were not there.Review of the incident report dated 03/25/2026, received on 03/31/2026, documented Resident 35 had a history of being verbally aggressive toward their roommate as of 12/31/2025, had an interaction with Resident 14 and their visitors on 03/15/2026, and a room move was complete on 3/17/2026. Resident 14 was interviewed on 03/25/2026 at which time they confirmed their roommate, Resident 35 was belligerent toward them and their visitors. There was no noted interviews with Resident 14 at the time of the incident or at the time of the room move. Reference WAC 388-97-0640 (2)(b).

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for one of five (Resident 31) residents reviewed for care planning. The failure to ensure the comprehensive care plan was implemented to maintain or attain the residents highest practicable well-being placed the residents at risk of not receiving services that would meet their needs, and a decreased quality of life.Findings included .Resident 31 was admitted to the facility on [DATE] with diagnoses to include chronic venous insufficiency (condition that damages leg veins and causes blood to pool in the legs), weakness, chronic pain and depression.Review of Resident 31's Activities of Daily Living (ADL) care plan documented they required extensive assist of 2 staff to turn and reposition in bed and also for personal care to be completed to help prevent them from rolling too close to the edge of the bed.Review of Resident 31's Kardex (resident care directive for Nursing Assistant Certified to provide care), dated 03/23/2026, documented they require extensive assist of 2 staff to turn and reposition in bed and for personal care to be completed to help prevent them from rolling to the edge of the bed with potential to fall.In a continuous observation on 03/23/2026 from 10:32 AM until 11:13 AM, Staff L, Nursing Assistant Certified (NAC), was observed to provide personal care, and incontinent care that required extensive bed mobility to Resident 31. Staff L, NAC, was observed to provide care independently and without another staff member. At 10:47 AM, Staff L stated to Resident 31 they had asked another NAC for assistance before they initiated the current care. Staff 31 encouraged Staff L to go get someone to help, Staff L stated they did not feel comfortable leaving them alone. At 10:51 AM, Staff S, NAC, knocked on the door, entered the room and asked if Staff L needed assistance with Resident 31's care.In an interview on 03/23/2026 at 11:51, Staff L stated they needed another staff member to complete care for Resident 31.In an interview on 03/30/2026 at 11:34, Staff B, Director of Nursing Services (DNS) stated their expectation was staff review the residents care plan, and Kardex to know what care a resident requires. Staff B stated their expectation was Resident 31 required 2 person assist for incontinent care, and bed mobility and that meant 2 staff were to provide care. WAC reference: 388-97-1020(1)(2)(a)(b)

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	505216	A. Building B. Wing	03/30/2026

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide assistance with grooming, including nail care for 3 of 4 residents (9, 31 and 37) reviewed who were unable to carry out their ADL's (activities of daily living) independently. Facility failure to provide the resident, who was dependent on staff for assistance with grooming, placed the residents and others at risk for poor hygiene, injury, unmet care needs and a diminished quality of life.Findings included .Review of the facility's policy, titled, ADL's revised July 2015, documented Nursing assistants will provide assistance with ADL's based on the resident's individualized plan of care. These interventions will be on the Kardex (tool that shows how to care for the resident), which is accessed in Point of Care (POC). Any changes noted in the resident's performance or abilities will be reported to the licensed nurse. <RESIDENT 7> Resident 7 admitted to the facility on [DATE] with diagnoses to include hemiplegia left hip fracture and osteoarthritis. In an interview and observation on 03/23/2026 at 11:54 AM, Resident 7 stated they had not had their toenails trimmed since admission. Their toenails were long extending over the toe. The resident asked who should be helping them with this. They stated they finally trimmed their fingernails because they were scratching them. In an interview on 03/25/2026 at 11:29 AM, Resident 7 stated they finally got their toenails trimmed when they asked Staff H, shower aide to clip them. Resident 7 stated Staff H told them that their nurse's aide could trim them as well. Review of the care plan dated 02/24/2026 showed the resident required the assistance of one person for grooming. <RESIDENT 9> Resident 9 admitted to the facility on [DATE] with diagnoses to include Diabetes Mellitus with neuropathy (nerve damage that occurs in people with diabetes), heart failure (chronic condition where the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen), and muscle weakness. Review of Resident 9' care plan documented no interventions related to fingernail care. Review of Resident 9's provider (Physician, Medical Doctor, Physician's Assistant or Advanced Registered Nurse Practitioner) orders documented they were to have nails checked by a Licensed Nurse every week. Review of Resident 9's Treatment Administration Record (TAR) dated March 2026 documented their nails had been checked on 03/7/2026, 03/14/2026, and 03/21/2026. In an observation on 03/23/2026 at 09:40 AM, Resident 9 was observed to have long fingernails with yellow and brown matter underneath. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/23/2026 at 10:33 AM, Resident 9 stated that the nurse was supposed to cut his fingernails and acknowledged their fingernails were long with brown matter underneath. In an observation on 03/24/2026 at 09:31 AM, Resident 9 was observed to have long fingernails with yellow and brown matter underneath. In an observation on 03/25/2026 at 11:21 AM, Resident 9 was observed to have long fingernails with brown and yellow matter underneath. In an observation on 03/27/2026 at 10:01 AM, Resident 9 was observed to have long fingernails with brown matter underneath. In an interview on 03/30/2026 at 10:17 AM Staff I, Licensed Practical Nurse (LPN) stated they had been told they were not supposed to cut diabetic resident's fingernails and podiatry was responsible to cut their fingernails. In an interview on 03/30/2026 at 11:34 AM, Staff B, Director of Nursing Services (DNS) stated the Licensed Nurses were responsible to cut Resident 9's fingernails since they were diabetic. <RESIDENT 31> Resident 31 was admitted to the facility on [DATE] with diagnoses to include chronic venous insufficiency (condition that damages leg veins and causes blood to pool in the legs), weakness, chronic pain and depression. Review of Resident 31's skin integrity care plan documented an intervention to keep their fingernails short, intervention initiated on 10/06/2022. In an observation and interview on 03/24/2026 at 10:35 AM, Resident 31 was observed to have long fingernails with matter underneath and stated staff cut their fingernails. In an observation on 03/25/2026 at 09:23 AM, Resident 31 was observed to have long fingernails with brown matter underneath. In an observation on 03/26/2026 at 08:49 AM, Resident 31 was observed to have long fingernails with discolored matter underneath. In an observation and interview on 03/27/2026 at 10:04 AM, Resident 31 stated their fingernails were still long, observed fingernails to be long with brown/yellow matter underneath. In an interview on 03/30/2026 at 09:29 AM, Staff F, Nursing Aide Certified (NAC), stated they review a resident Kardex (resident care directive for NAC's to provide care) to know what care the resident requires. Staff F stated nail care can be done by NAC's unless the resident was diabetic. Staff F stated if they saw a resident who had long nails or matter underneath the nails, they would offer to clean out the matter from under the nails and offer to trim the nails. Review of Resident 31's Kardex dated 03/23/2026 documented to keep fingernails short in the resident care section. (continued on next page)

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	505216	A. Building B. Wing	03/30/2026

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/30/2026 at 10:17 AM, Staff I, LPN, stated they had not looked at Resident 31's nails. In an interview on 03/30/2026 at 11:34 AM, Staff B stated their expectation is that staff review residents care plans and Kardex's to know what care a resident requires. <RESIDENT 37> Resident 37 admitted to the facility on [DATE] with diagnosis to include cerebellar Review of Resident 37's care plan, dated 07/18/2024, showed Resident 37 had an ADL self-care performance deficit related to stroke, left side weakness and cerebellar ataxia. The care plan showed the residents required one person extensive assistance for all grooming. Review of a progress note dated 07/17/2025 at 4:32 PM showed Resident 37 had self-inflicted scratches to both cheeks. Review of a progress note on 01/07/2026 at 5:56 PM, showed Resident 37 had scratches on their face and bloody fingernails. Resident replied yes to facial itching and nails were trimmed. In an observation on 03/24/2026 at 8:46 AM Resident 37 was in the activity room watching TV. Their fingernails were long and jagged. In an observation on 03/26/2026 at 9:00 AM Resident 37 was up in their wheelchair across from the nurse's station. The resident had a large band aid on the left side of face. Review of a progress note on 03/26/2026 at 7:14 AM, showed self-inflicted scratches found below the residents' left ear and their cheek. Fingernails were documented as sharp. Review of a provider visit note dated 03/28/2026 at 8:22 AM, documented that on 03/26/2026, two self-inflicted scratches were noted on the face, one below the left ear with minor bleeding and one on the right cheek without bleeding, both cleaned and dressed with antibiotic ointment and elastic bandages. The note showed that on 03/27/2026, skin assessment documented two new scratches, 4 centimeter (cm) on the right and 2 cm below the left ear. In subsequent observations on 03/27/2026 at 9:13 AM and 3:09 PM Resident 37's nails remained long and jagged. In observations on 03/30/2026 at 9:15 AM and 3:44 PM, Resident 37 were asleep in their recliner and nails remain untrimmed and long. In an interview on 03/30/2026 at 9:46 AM, Staff F, NAC stated the NACs were expected to clip nondiabetic residents' fingers and toenails. Staff F stated nurses did nail care for diabetic residents. They stated Staff H usually clipped nails during showers and some NAC's expected Staff H to clip them. In an interview on 03/30/2026 at 10:24 AM, Staff I, LPN stated they were unsure if the Podiatrist or nurses were expected to trim toenails. Staff I stated Podiatry did not come in every month but visited every 3 months. Staff I stated they had asked several Director of Nurses (DNS) who was responsible (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to do diabetic nail care and they never get an answer. Staff I stated the NACs are to clip finger and toenails for residents that are not diabetic. In an interview on 03/30/2026 at 12:19 PM, Staff B, DNS stated preferably the shower aide, or aide should cut nails unless the resident is diabetic. Staff B was unaware Resident 7 asked to have their toenails trimmed for a month and Resident 8 still had long jagged nails after self-inflicted facial scratches last week. Staff B stated podiatry came to the facility every 3 months. Reference: (WAC) 388-97-1060 (2) (c)

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	505216	A. Building B. Wing	03/30/2026

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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 2 of 3 residents (Resident 14 and 27) reviewed received the necessary care and services in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. The failure to secure a wound vacuum (wound vac-medical device that uses controlled suction to speed healing of chronic or deep wounds) when ordered, provide pressure relieving devices and supplements as ordered for Resident 27 placed them at risk for delay in healing and poor quality of life. The failure to coordinate timely a timely orthopedic appointment per resident's orders and preferences placed them at risk for delay in healing for Resident 14. These failures placed all residents at risk for delay in care and treatment, confusion, and potentially poor quality of life. Findings included .<RESIDENT 14>Resident 14 admitted to the facility on [DATE] with diagnoses to include fracture and urinary tract infection.In an interview on 03/24/2026 at 8:55 AM Resident 14 stated they were concerned about a follow up appointment with an orthopedic surgeon. Resident 14 stated they had been at the facility for 11 days and had been asking for an appointment with their orthopedic surgeon. Resident 14 stated they asked the nurse and several nursing assistants but had not heard anything.Review of Resident 14's hospital Discharge summary dated [DATE] documented orders for them to follow up with their primary care physician and orthopedic physician.Review of Resident 14's provider note dated 03/12/2026 documented order for them to see an orthopedic provider for a consultation. Review of Resident 14's care plan dated 03/19/2026 documented they were to follow up with an orthopedic provider.In an interview on 03/26/2026 at 9:53 AM Staff U, Health Information Management HIM), stated they were responsible for scheduling appointments and worked alongside Staff D, Licensed Practical Nurse (LPN), to schedule and coordinate appointments. Staff U stated a fax was sent to the orthopedic clinic on 3/12/2026 to coordinate an appointment. Staff U stated an appointment was scheduled on 03/25/2026 after contact with the orthopedic clinic on 03/20/2026 revealed they had not received the initial fax sent on 03/12/2026. Staff U stated referrals or appointments needed for residents are completed at admission. In an interview on 03/26/2026 at 10:21AM Staff D, LPN, stated ordered referrals and follow up appointments were noted, put into the clinical record and communicated to Staff U, HIM to schedule. Staff D stated they spoke to residents about their appointments to ensure they were on the same page. Staff D stated they had not spoken to Resident 14 about their orthopedic appointment and were not aware they had concerns about the scheduling of an appointment. Review of Resident 14's progress notes from 3/11/2026 through 3/23/2026 documented no information related to scheduling an orthopedic appointment. Review of fax cover sheet dated 03/12/2026, from Staff D, LPN, to the orthopedic clinic documented Referral to set up ortho [orthopedic], New patient. Call to set up appt with [Staff U]. There was no confirmation that the fax had gone through. In a follow up interview on 03/27/2026 at 3:09 PM Resident 14 stated they were told about the orthopedic appointment scheduled on 03/25/2026 until about a half an hour prior to it occurring. Resident 14 stated the nursing assistant came in and said they had an appointment with the orthopedic doctor. Resident 14 stated no notice was given to them in writing.<RESIDENT 27>Resident 27 admitted to the facility on [DATE] with diagnoses to include pressure ulcer of the left buttock.Review of Resident 27's Minimum Data Set (MDS-an assessment tool), dated 03/12/2026, documented they had skin care related to pressure ulcers.Review of Resident 27's Care Area Assessment (CAA-tool used to create care plans) dated 3/16/2026 documented Resident 27 had multiople skin related conditions to include a pressure ulcer to their left buttock and wound care provided as per wound clinic orders. Resident 27 was followed by the hospital wound clinic and orders were to be followed per their recommendations and orders.Review of Resident 27's care plan dated 03/17/2026 documented that they had a pressure ulcer to their left buttock and were at risk for development of additional pressure ulcers due to decreased mobility with the goal of the pressure (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ulcer would show signs of healing within infection. Interventions included administering treatments as ordered and monitor for effectiveness, continued wound clinic appointments as scheduled, provide supplements as ordered (Vitamin C and Zinc) and wound care per order from the wound care clinic.Review of Resident 27's wound care note dated 03/12/2026 and 03/19/2026 documented orders for the following:-Specialty Bed/Mattress for pressure reduction. Patients need low air loss mattress overlay, group 2 specialty mattress (designed for hospital beds and features alternating pressure, low pressure, lateral rotation to reduce pressure ulcers).-Take Vitamin C 1000 milligrams (mg) daily by mouth-Take Zinc 25 mg by mouth daily-Return appointment in one week-please initiate wound vac (specialty medical device used for wound healing), order and send to next appointment.Review of Resident 27's order summary as of 03/23/2026 documented they had orders for the following:-Obtain alternating pressure mattress related to pressure wounds to left buttocks and bilateral thighs dated 03/06/2026- Vitamin C Oral) Give 500 mg by mouth one time a day for wound healing dated 03/09/2026-Zinc Sulfate Tablet 50 mg by mouth one time a day for wound healing dated 03/09/2026-Wound Care for left buttocks and use of wound vac dated 03/20/2026On 03/23/2026 at 2:51 PM, 03/24/2026 at 9:13 AM and 3/26/2026 at 10:56 AM observed Resident 27's bed and mattress. Resident 27's bed was observed not to have an alternating pressure mattress.In a review of Resident 27's progress notes dated 03/20/2026 documented the wound vac was placed per wound clinic orders, 8 days after receipt of the wound clinic order.In an interview on 03/26/2026 at 12:13 PM Staff I, Licensed Practical Nurse, stated Resident 27 had their wound vac placed on 03/20/2026.In an interview on 03/27/2026 at 10:11 AM Staff D, LPN, stated they attempted to obtain a wound vac for Resident 27 through a medical supply company, however, was notified the facility did not have a contract and had to find a different company. Staff D stated they informed the wound clinic about the delay for Resident 27's wound vac and stayed in contact with them. When asked about orders for the alternating pressure mattress and supplements (Vitamin C and Zinc) Staff D stated they were standing orders given by the wound clinic for their patients and due to Resident 27's mobility, independent with walking, an alternating pressure mattress was not indicated. Staff D stated Resident 27 did not have an alternating pressure mattress on their bed. Staff D stated they had not documented their conversations with providers with regard to the wound vac in Resident 27's medical record.Reference WAC 388-97-1060(1)(3)(b)

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	505216	A. Building B. Wing	03/30/2026

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to comprehensively assess, and revise interventions as needed to prevent or address significant weight loss for two of five residents (3 and 11) reviewed for nutritional status and weight loss. These failures placed residents at risk for significant decline in nutritional status and related complications.Findings included .<RESIDENT 3> Resident 3 was admitted to the facility on [DATE] with diagnoses to include orthopedic aftercare (surgery of left femur), and a urinary tract infection (infection of any part in the urinary system). Review of Resident 3's MDS (resident assessment tool) admission assessment dated [DATE] documented they had a potential nutritional risk due to their leg fracture and urinary tract infection. Review of Resident 3's nutrition care plan documented they were to have weekly weights, Registered Dietitian (RD) to evaluate and make diet change recommendations as needed, and to monitor labs, all interventions were initiated on 03/06/2026. Review of Resident 3's provider orders showed they were to have weekly weights, with a start date of 02/28/2026. Review of Resident 3's weights documented on 02/21/2026 their weight was 187.6 pounds (lbs), and on 03/21/2026 their weight was 166.2 lbs, which was an 11 percent (%) decrease in 1 month. Resident 3's weights were obtained on 02/21/2026, 02/28/2026, 03/18/2026 and 03/21/2026, which were not consistent with the provider order for weekly weights. Review of Resident 3's admission Nutritional Assessment, dated 02/24/2026, documented they had a nutritional goal to maintain current weight without significant weight change, and interventions to monitor oral intake, weights, labs. There were no additional nutritional assessments documented. Review of Resident 3's lab results, dated 02/23/2026, documented low protein and albumin levels (low levels of protein in the blood). In an interview on 03/27/2026 at 1:42 PM, CC1, Registered Dietitian, stated they had not evaluated Resident 3, and could only find the nutritional assessment dated [DATE]. CC1 stated Resident 3 had a crazy weight loss documented. CC1 confirmed Resident 3 had gone over 2 weeks without a documented weight, from 02/28/2026 until 03/18/2026 and stated they would expect to get the resident reweighed to check accuracy of decreased weight. CC1 stated they had not added any interventions for nutritional decline as they had not identified or known about their weight loss. CC1 stated they would expect the facility to initiate interventions based on Resident 3's weight loss. In an interview on 03/30/2026 at 09:29 AM, Staff F, Nursing Assistant Certified (NAC), stated they receive a list of residents who need to be weighed from their nurse. Staff F, NAC, stated they are not responsible to document a resident's weight. In an interview on 03/30/2026 at 10:17 AM, Staff I, Licensed Practical Nurse (LPN), stated the nurses are responsible to document weights, and confirmed they were able to see the last documented weight when entering the new weight, and stated most residents were weighed weekly. Staff I, LPN, stated Staff B, Director of Nursing Services (DNS) and Staff D, Licensed Practical Nurse/Resident (continued on next page)

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	505216	A. Building B. Wing	03/30/2026

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Care Manager (LPN/RCM) reviewed resident's weights weekly and notified the Registered Dietitian. Staff I stated they were unaware of Resident 3's weight loss and confirmed weekly weights had not been documented. Staff I stated they would ask for a resident to be reweighed if there was a weight loss. and would be able to provide supplements such as mighty shakes, ice cream, and pudding. In an interview on 03/30/2026 at 11:34 AM, Staff B, DNS, stated their expectation for resident weights was they are weighed the first 3 days they are here, and then weekly weights. Staff B stated NAC's obtain weights and the Licensed Nurse's document the weights. Staff B stated they would expect at least 3 days of daily weights to be obtained if there was weight loss documented and checked for accuracy. Staff B stated the Registered Dietitian sends weekly updates with resident name, and if weight increased or decreased. Staff B stated they were unaware of Resident 3's weight loss and had not been identified. Staff B confirmed Resident 3 did not have weekly weights documented. Staff B stated they meet with the Registered Dietitian every two weeks to discuss residents in the nutrition meetings. Staff B confirmed there were no other nutrition notes for Resident 3. Staff B stated they used to get weekly weight report weekly from the previous Resident Care Manager (RCM) who left in December 2025 and stated they had not remembered to do the weekly weight report . <RESIDENT 11> Resident 11 admitted to the facility on [DATE] with diagnoses to include heart attack, heat failure, and depression. Review of Resident 11's weights documented on 01/27/2026 they weighed 105.8 pounds and on 03/13/2026 they weighed 94.2 pounds, which was a 12.3 percent weight loss in 73 days. Review of Resident 11's admission care area assessment (CAA-tool used to develop care plans) dated 02/05/2025, documented they were at risk for nutritional risk/decline related to their variable meal intake and minimal appetite. Interventions documented included diet downgrade to soft and bite size, addition of supplemental shakes, and seen by the dietician on 02/03/2026. The goal was to minimize risk and improve appetite. Review of Resident 11's registered dietician admission review dated 02/03/2026 documented the goal was for no significant weight changes, the nutritional intervention/recommendation was the implementation of supplemental shakes twice a day to support meal intake and weight. Review of Resident 11's provider note dated 02/16/2026 and 03/12/2026 documented resident had adult failure to thrive, noted persistent weight loss, and decreased oral intake due to advanced age. There were no recommendations or interventions identified. In an interview on 03/27/2026 at 1:33 PM, Collateral Contact 1 (CC 1), Registered Dietician, stated they had taken over as the dietician for the facility in October 2025 and visit the facility every Tuesday. CC 1 stated the facility contacted them during the week if there is something they need to review, otherwise they meet every other Tuesday for nutrition at risk meetings. CC 1 stated they met with the resident care managers, the director of nursing services and sometimes the minimum data set nurse. CC 1 stated Resident 11 had significant weight loss, was underweight at the hospital, had been refusing snacks at bedtime and the supplemental shakes. CC 1 stated Resident 11 was discussed on 3/17/2016 with no additional recommendations and hospice services were being considered. CC 1 stated they were to review Resident 11 with the facility on 03/03/2026 but did not (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	due to facility staff availability. In an interview on 03/30/2026 at 10:17 AM Staff I, LPN, stated when a resident had a weight that indicated weight loss, usually three pounds, they were put on daily weights for three days and the dietician was notified. Staff I stated Resident 11 did not like the supplemental shakes and would consume about 50-75 percent of their meal. Staff I stated they did not know why Resident 11 was losing weight. When asked if Resident 11 had been seen by the dietician they stated they did not know, they had not spoken to the current dietician, and the previous dietician would talk with the nurses. Staff I stated they did not participate in the nutrition at risk meetings with the dietician. In an interview on 03/30/2026 at 11:48 AM Staff B, Director of Nursing Services, stated they expected themselves and the resident care manager to be notified of weight loss of a resident so they could be reviewed in the nutrition at risk meetings. Reference WAC 388-97-1060(3)(h)

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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** .Based on observation, interview and record review, the facility failed to ensure respiratory care and services were provided in accordance with Physician's orders and accepted professional standards of practice for 2 of 2 residents (Resident 11 and 44) reviewed for respiratory care. The facility failed to ensure a Trilogy device (portable ventilator-a medical device that mechanically moves breathable air into and out of the lungs to assist or replace spontaneous breathing) orders were complete and in place, to include the prescribed pressure settings, checking, refilling and cleaning of the device. The facility failed to ensure oxygen (O2) was administered with appropriate physician orders to titrate O2 and change O2 tubing. These failures placed residents at risk for ineffective assisted ventilation, shortness of breath, decreased oxygen saturation and other respiratory complications.Findings included . Review of the facility's undated policy titled, Oxygen Safety and Storage, documented that nasal cannulas (medical tube that delivers oxygen into the nose), tubing, filters and/or water will be changed weekly.<RESIDENT 11> Resident 11 admitted to the facility on [DATE] with diagnoses to include heart failure and heart attack. In an observation on 03/23/2026 at 12:06 PM observed Resident 11 laying in their bed, flat, wearing a nasal cannula (flexible tube used to deliver oxygen) tubing, undated, attached to an O2 concentrator set at 1.5 liters per minute (lpm). In an observation on 3/24/2026 at 12:28 PM observed Resident 11 laying in their bed, head of bed elevated, with a nasal cannula to the left side of their face, not inserted in their nose, the tubing dated 03/24/2026. Review of Resident 11's Medication and Treatment Administration Record for February 2026 documented: - an order to change the O2 tubing and water one time a day every Sunday for O2 with a start date of 02/08/2026 and discontinued date of 03/18/2026. -an order for O2 per nasal cannula to keep O2 saturation greater than 90 percent, not to exceed four lpm with a stat date 02/06/2026 and discontinued date of 03/03/2026. -an order for titrate (the process of adjusting a dosage incrementally (increasing or decreasing) over time to find the lowest effective amount that provides maximum benefit with minimal side effects) resident off O2 start date 02/19/2026. Review of Resident 11's care plan dated 02/06/2026 documented they had O2 therapy related to their respiratory status. Interventions included to give medications as ordered by the physician and the O2 settings were as O2 as needed per nasal cannula to keep O2 saturations greater than 9-0 percent and not to exceed four lpm. Review of Resident 11's progress notes from 01/27/2026 through 3/23/2026 documented they were dependent on O2. In an interview on 03/30/2026 at 10:17 AM Staff I, Licensed Practical Nurse, stated Resident 11's O2 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	orders should have had a specific order and parameters for titration off O2. Staff I stated Resident 11 was not able to titrate off O2 and sometimes they used three lpm and other times 1.5 lpm. <RESIDENT 44> Resident 44 was admitted to the facility on [DATE] with diagnoses to include chronic respiratory failure, severe persistent asthma, chronic obstructive pulmonary disease (COPD - a progressive lung disease that makes breathing difficult) and dependence on respiratory ventilator. Review of Resident 44's physician orders documented oxygen (o2) to be administered at two liters per minute (lpm) through a nasal cannula and that the Trilogy machine would be work at bed time or during sleep as needed. Settings section was left blank. In an observation on 03/23/2026, at 9:35 AM, Resident 44 was seen with a nasal cannula on and o2 set to 2 lpm. Resident 44 had a Trilogy machine on their night stand and the mask had white debris on it. No label or date was observed on the o2 tubing. In an observation on 03/23/2026, at 3:14 PM, Resident 44's o2 tubing was on the floor, no label or date was observed on the tubing, and Trilogy mask had white debris on it. In an observation on 03/24/2026, at 12:43 PM, Resident 44's o2 tubing was dated with 03/24/26 and Resident 44 stated they had changed the tubing in the morning. Trilogy mask had white debris on it. Review of Resident 44's care plan, dated 03/20/2026, had no documentation related to respiratory needs including the Trilogy machine and oxygen. In an interview on 03/26/2026, at 12:22 PM, Staff D, Resident Care Manager/Licensed Practical Nurse, stated that when a resident is admitted on oxygen, they have batch orders that should be in place. The batch orders should include changing the o2 tubing and water weekly, o2 lpm, and monitoring for skin breakdown. Staff D stated an oxygen in use sign should be placed outside of the resident's door. Staff D confirmed that Resident 44 did not have a respiratory care plan for o2 or Trilogy machine, that physician orders did not include Trilogy settings or cleaning for o2 or Trilogy machine and mask. In an interview on 03/26/2026, at 3:55 PM, Staff B, Director of Nursing/Registered Nurse, stated that their expectation for a resident on oxygen would have active orders to include the o2 lpm, changing the o2 tubing with a label that includes date and initials. Staff B's expectation for residents on Trilogy machines would be to have active orders that would include their settings, if supplemental o2 is needed with it, assistance needed and cleaning of the machine. Refer to WAC 388-97-1060(3)(j)(vi)

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	505216	A. Building B. Wing	03/30/2026

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

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure 1 of 1 residents (Resident 6), reviewed for hemodialysis (medical procedure that uses a machine to filter and clean the blood when the kidneys are failing), had consistent, completed and accurate assessments on the facility's dialysis communication form (a form containing vital information about the resident which is sent to the dialysis center for coordination of care and services). This failure placed the resident at risk for medical complications and unmet care needs.Review of the undated facility policy titled, Dialysis, documented that the licensed nurse will complete the post dialysis assessment upon the resident's return to the facility from dialysis.<RESIDENT 6>Resident 6 was admitted to the facility on [DATE] with diagnoses to include end stage renal disease (the final stage of long-term kidney failure requiring dialysis to survive).Resident 6 has dialysis every Tuesday, Thursday, and Saturday.In a record review of post dialysis communication forms in a look back period from 01/28/2026 - 03/26/2026, there were 12 missing forms out of 25 opportunities.In an interview on 03/26/2026, at 3:09 PM, Staff Q, Licensed Practical Nurse (LPN), stated that after Resident 6 returns from dialysis that they are to do the post dialysis communication form and document it in the electronic health record (EHR).In an interview with Staff D, Resident Care Manager/LPN, confirmed missing dates for post dialysis communication forms. Staff D stated that the evening shift nurse should complete the post dialysis form when Resident 6 returns from dialysis and documented in the EHR. Reference WAC 388-97-1900(1)(5)(c)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5 percent (%, unit of measure). During observation of 26 opportunities for error, 3 of the 26 medications were administered late, resulting in an error rate of 11.54 %. Further, Resident 2 received medications when they should have been held. These failures placed residents at risk for side effects, unnecessary medications, and/or reduced medication effectiveness due to improper administration.Findings included .Review of the facility policy titled, Medication Administration undated showed medication administration will be provided to residents in a manner that is safe and by the route directed through the Primary Care Provider's (PCP) orders. All persons administering medicine will understand and utilize the 6 Rights of medication administration including right time by checking the frequency of the ordered medication or treatment, double checking that they are giving the ordered dose at the correct time and confirming when the last dose was given. <Resident 5>Resident 5 was admitted on [DATE]. According to the admission MDS assessment dated [DATE], the resident was cognitively impaired.According to the American Diabetes Association (ADA) Standards of Care, Glargine (a long-acting basal insulin) is to be administered at the same time everyday to prevent doses overlapping or gaps in coverage.During an observation on 03/24/2026 at 9:43 AM, Staff I, Licensed Practical Nurse (LPN), administered Resident 5's 8:00 AM dose of Glargine Insulin about 1.75 hours after it was scheduled.Review of Resident 5's physician orders directed nurses to administer Glargine Insulin at 8:00 AM.In an interview on 03/26/2026 at 2:52 PM, Staff I, LPN stated Resident 5 likes their insulin to be administered after they eat. Staff I stated they did not know if the medication order or care plan specified that. <RESIDENT 9>Resident 9 was admitted to the facility on [DATE]. According to the quarterly MDS dated [DATE], the resident was cognitively intact. Review of Resident 9's physician orders showed the resident had an order for Aspirin 81 and Losartan Potassium was to be administered at 8:00 AM. In an observation on 03/24/2026 at 9:27 AM, Staff I was observed to administer Resident 9's medications including aspirin and Losartan Potassium. The medication was given about one and half hours late after the physician orders indicated they were to be administered.In an interview on 03/26/2026 at 2:52 PM, Staff I, LPN said there were only two nurses on AM shift and one day a week they were floundering. Staff I stated flexible med pass was set up as any med given once a day. Staff I stated that if the medication is ordered twice a day there are specific times used for them to be administered. Staff I stated they pass medications to an average of 20 residents and last week they had 23 residents to pass meds to. <RESIDENT 2>Resident 2 admitted on [DATE] with diagnoses to include hypertensive (high blood pressure) heart disease with heart failure.Review of the physician's orders showed the nurses were to hold the Doxazosin Mesylate if the systolic blood pressure (SBP, top number of BP) was less than 100.Review of Resident 2's January and March 2026 Medication Administration Records documented that Doxazosin Mesylate 6 MG, a medication to treat high blood pressure was administered on 01/12/2026 when the blood pressure was 99/58 and on 03/16/2026 for a BP of 96/57.In an interview on 03/30/2026 at 11:18 AM, Staff E, LPN stated medications were to be passed one hour before or after scheduled time. In an interview on 03/30/2026 at 12:13 AM, Staff B, Director of Nursing Services stated the facility policy was that all medications should be given within an hour time that they are due. Staff B was unaware that Resident 5 and 9's medications were given late and Resident 2 had received Doxazocin outside of the parameters ordered. This is a repeat deficiency from 05/14/2025 Reference WAC 388-97-1060 (3)(k)(ii)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from significant medication errors when medications were not administered per physician orders for 1 of 5 residents (Resident 35) and medications not documented when administered for 1 of 1 residents (Resident 7) reviewed for medication management. These failures placed residents at risk for medical complications, unintended health consequences, and a diminished quality of life.Findings included .Review of the facility's undated policy titled, Medication Administration, documented that that medications will be documented after giving the ordered medication. Staff are to enter all required data including the time, route, and any other specific information.<RESIDENT 7> Resident 7 was admitted to the facility on [DATE] with diagnoses to include bipolar disorder (mental health condition characterized by intense, alternating mood episodes), major depressive disorder, anxiety disorder, and post-traumatic stress disorder. Review of Resident 7's physician orders documented Clonazepam 1 milligram (mg) tablet by mouth every 12 hours as needed for anxiety active as of 03/23/2026. Review of Portage Hall's (Resident 7's hall) narcotic book (a secure log to keep track of controlled substances), documented on 03/24/2026 one dose administered at 3:31 PM and 39 tablets remaining. Another tablet is documented on 03/24/2026 at 8:16 PM but no dose signed out, no nurses signature and number of tablets remaining was not documented. There was a sticky note attached to this missing documentation that stated, Staff C, Registered Nurse (RN) please sign. Review of Resident 7's, March 1st - 30th, 2026, medication administration record (MAR) did not have documentation of the administered Clonazepam on 03/24/2026 at 3:31 PM. In an interview on 03/26/2026, at 3:55 PM, Staff B, Director of Nursing (DNS)/RN, stated that they did not know about the missing signature in the narcotic book but that they would figure it out immediately. Staff B stated that their expectation of administered medication is to do be documented in the MAR. <RESIDENT 35> Resident 35 was admitted to the facility on [DATE] with diagnoses to include dementia with behaviors. Review of Resident 35's admission orders dated 12/01/2025 from their prior placement documented they were prescribed Seroquel (an antipsychotic medication) 25 milligrams (mg) every 24 hours as needed for agitation. The admission orders were reviewed by two different nurses on 12/01/2025 and signed by the provider on 12/02/2025. Review of Resident 35's admission orders dated 12/01/2025 for the facility documented they were prescribed Seroquel 25 mg bedtime for dementia with behavioral disturbances. Review of Resident 35's pharmacy review dated 12/30/2025, 29 days after admission, documented they were taking Seroquel as needed at their prior placement, ordered at time of admission to the facility, and requested clarification from the provider. The provider reviewed on 12/31/2025 and (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented to continue Seroquel as scheduled due to severity of agitation. In an interview on 03/26/2026 at 3:25 PM Staff D, Registered Nurse-Resident Care Manager, stated Resident 35 admitted with Seroquel 25 mg at bedtime for dementia with behavioral disturbances. Staff D stated there was a triple check process to ensure that orders were transcribed correctly, two nurses checked and then the provider. When asked about the discrepancy in orders from admission, Staff D stated the provider may have wanted Resident 35's medication changed at admission. In an interview on 03/30/2026 at 2:38 PM Collateral Contact 2, CC 2, Doctor of Nurse Practitioner, stated they were going off their memory and believed they had gotten a call from the facility requesting Seroquel to be routine when Resident 35 admitted . Review of Resident 35's electronic health record from 12/01/2025 through 3/23/2026 documented no order at admission nor at the time of the pharmacy review, changing Seroquel from as needed to routine. Reference WAC 388-97-1060 (3)(k)(iii)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure proper labeling of insulin (injectable medication that regulates blood sugar) in 1 of 2 medication carts (Portage Hall Medication Cart), failed to correctly monitor temperatures of vaccines in medication fridge, and secure medication carts according to current standards of practice in 2 of 2 medication carts (Portage Hall and Ship Harbor Hall Medication Carts), and 1 of 1 medication rooms reviewed for medication storage and handling. These failures placed residents at risk of receiving compromised or ineffective medications, unauthorized access to medications and biologicals, and potential drug misuse.Findings included . Review of the undated facility policy titled, Medication Administration, documented that general administration practices include checking the medications for expiration dates, keep medication cart locked when not in physical control, and to document medications as given on the medication administration record (MAR).Review of the Center for Disease Control (CDC) guidelines titled, Vaccine Storage and Handling, dated 03/29/2026, documented to check and record temperatures with the minimum and maximum temperatures at the start of each workday. If the temperature monitoring device does not read minimum/maximum temperatures, then you are to check and record the current temperature a minimum of two times per workday.<MEDICATION CART> In an observation on 03/27/2026 at 11:44 AM, Staff O, Licensed Practical Nurse (LPN) left the Portage Hall medication cart unlocked and unsupervised for 3 minutes. Staff O, LPN returned to the cart and voiced shoot. Staff O opened the cart without utilizing keys for their next medication administration. <UNATTENDED MEDICATIONS> In an observation on 03/27/2026 at 11:54 AM, Staff O, LPN and this surveyor observed a brown round pill on the floor in between room [ROOM NUMBER] and 6. Staff O commented the pill was someone's Senna (laxative) and it was wet so somebody must have spit it out. In an interview on 03/30/2026 at 11:18 AM , Staff E, LPN stated med carts were to be locked if the nurse was not in front of it. In an interview on 03/30/2026 12:13 PM, Staff B, Director of Nursing was not aware Staff O left their med cart unlocked and unattended. Staff B stated the medication cart should be locked <PORTAGE HALL MEDICATION CART> In a joint observation and interview on 03/26/2026, at 10:20 AM, with Staff K, Licensed Practical Nurse (LPN), the Portage Hall Medication Cart had three open Glargine insulin pens without an open or discard date. Staff K confirmed no open or discard date was documented on the insulin pens Staff K stated that the process for an open insulin in the medication cart without an open or discard date should have been discarded and then to get a new insulin pen out of the fridge and date it with the open and discard date. In an observation on 03/26/2026, at 11:37 AM, Portage Hall Medication Cart was observed unlocked and unattended and the laptop had a resident's protected health information open. Staff K, LPN, (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	returned to the cart at 11:39 AM. Staff K acknowledged the unlocked cart and then locked it. Staff K stated it should have been locked and the laptop screen locked. <MEDICATION ROOM> In an observation on 03/24/2026, at 12:50 PM, the medication fridge in the medication room contained Spikevax Covid vaccine, pneumonia vaccine and influenza vaccine and an instant read analog thermometer. In review of the fridge temperature monitors, it was documented temperatures were checked and documented once only on night shift. In an interview on 03/24/2026, at 12:54 PM, Staff C, Registered Nurse (RN), stated that fridge temperatures are only checked once daily by night shift. In an interview on 03/27/2026, at 2:33 PM, Staff B, Director of Nursing/RN, stated that their medication fridge, even with vaccines, only needs to be checked once a day and night shift nurse checks and documents that. This is a repeat deficiency from 05/09/2024 and 05/14/2025. Reference: (WAC) 388-97-1300 (2)