STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505407	A. Building B. Wing	01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Rehabilitation and Care Center	5925 47th Avenue NE Marysville, WA 98270

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 honor resident rights related to providing care and treatment for chemotherapy for 1 of 1 resident (Resident 36). This failure placed residents at risk of unmet medical needs, emotional upset, and diminished quality of life. Findings included.<RESIDENT 36>Resident 36 admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include malignant extensive stage lung cancer (end stage lung cancer has spread to other parts of the body) and metastasis to liver (cancer has spread to the liver). According to the quarterly Minimum Data Set (MDS-an assessment tool) assessment, dated [DATE], the resident was cognitively intact. In an interview on [DATE] at 1:49 PM, Resident 36 stated they were supposed to have chemotherapy, but the facility told them they did not take care of residents with chemotherapy and did not provide transportation for chemotherapy. In an interview on [DATE] at 2:43 PM, Resident 36 stated they were not aware they could not do chemotherapy before being admitted to the facility and they always wanted to get their chemotherapy. The resident stated they were not aware the facility canceled their chemotherapy appointments. In an interview on [DATE] at 2:33 PM, Resident 36 stated they were supposed to have six cycles of chemotherapy, but they only received two while they were in the hospital in July and August last year. The resident stated they wanted to be discharged to another place which could provide chemotherapy care. In an interview on [DATE] at 9:15 AM, Collateral Contact (CC) 1, Resident 36's Caregiver, stated the facility had not allowed the resident to have chemotherapy or have port placement since admitted to the facility [DATE]. CC1 stated the facility stated the nurses in the facility could not take care of the port or take care of the resident when they returned from chemotherapy treatments. Review of a hospital consultation note dated [DATE] at 9:44 PM, documented Resident 36's chemotherapy treatment would consist of six cycles of chemotherapy up to six months, which could be given every 21 days for the initial three days of the cycle. Review of a hospital case manager note dated [DATE] at 8:23 AM, showed Resident 36 would need outpatient chemotherapy for three days every 21 days. Review of a facility provider note dated [DATE] at 9:33 AM, documented Resident 36 to follow up with oncologist for next cycle every 21 days. Review of a facility provider note dated [DATE] at 9:13 AM and a progress note dated [DATE] at 11:30 AM, documented Resident 36 to follow up with oncologist on [DATE] at 11:00 AM and [DATE] at 12:45 PM, [DATE] at 11:00 AM for labs, [DATE] at 11:00 AM, [DATE] at 10:00 AM, at [DATE] at 2:20 PM for infusions. Review of an oncology clinic provider visit note dated [DATE] at 1:24 PM, the oncologist documented Resident 36 was to return on [DATE] for cycle two infusion and to follow up for port placement. Review of a facility provider progress note dated [DATE] at 11:35 AM, documented Resident 36 was scheduled for port placement on [DATE] for chemotherapy. Review of an oncology clinic note dated [DATE] at 3:46 PM, documented the facility called and canceled all Resident 36's appointments and the resident would be told to call and reschedule everything once they discharged from the facility. Review of Resident 36's Electronic Medical Record (EMR) showed there was no documentation the resident was notified of any above appointment cancellations or changes. Review of a telephone encounter note dated [DATE] at 12:00 PM, documented the facility (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505407	A. Building B. Wing	01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Rehabilitation and Care Center	5925 47th Avenue NE Marysville, WA 98270

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	requested to push back Resident 36's chemotherapy schedule until after they discharged from facility on [DATE] due to the resident could not attend chemotherapy appointments on rehabilitation therapy days per insurance authorization. Review of a hospital note dated [DATE] at 3:35PM and [DATE] at 11:26 AM, documented Resident 36 had not been able to follow up for outpatient chemotherapy after being admitted to SNF since [DATE] and the chemotherapy appointment was initially scheduled on [DATE] and pushed back by the facility till [DATE] and then all appointments cancelled by the facility. Review of an oncology clinic note dated [DATE] at 7:34 AM, documented the provider ordered to contact the facility and scheduled cycle three chemotherapy on [DATE]. The following note dated [DATE] at 9:56 AM, documented the facility requested to schedule the resident out by two weeks to allow the resident to receive physical therapy and occupational therapy. The note documented Resident 36 had future appointments scheduled for [DATE] at 4:00 PM, [DATE] at 11:00 AM, [DATE] at 3:00 PM, [DATE] at 3:20 PM, [DATE] at 4:00 PM. In a follow up interview on [DATE] at 2:44 PM, CC3, Registered Nurse in oncology clinic, confirmed Resident 36 did not go to any of the above appointments. Review of an oncology clinic note dated [DATE] at 11:04 AM, documented the clinic staff called and spoke with the facility to schedule an appointment for Resident 36 on [DATE]. The facility declined to schedule the available appointment on [DATE] at 4:00 PM related to transportation availability and rescheduled for [DATE] at 2:00 PM. Review of an oncology clinic note dated [DATE] at 2:24 PM, documented Resident 36 was a no show for their appointment on [DATE] at 2:00 PM. Review of Resident 36's Electronic Medical Record (EMR) for [DATE] revealed no documentation about if Resident 36 attended the appointment scheduled that day and/or what the reason for missing the appointment was. Review of an oncology clinic note dated [DATE] at 12:19 PM, documented the facility stated they could transport the Resident 36 to their office for office visits but not for treatment and there was no anticipated discharge date for them. Review of an oncology clinic provider visit note dated [DATE] at 9:42 AM, documented the facility could not make the resident for chemotherapy appointment since last cycle on [DATE] in the hospital and the resident wanted to resume the chemotherapy as soon as possible. Review of an oncology clinic note dated [DATE] at 4:03 PM, documented they contacted the facility and spoke with Staff D, Receptionist, to schedule port placement and to resume chemotherapy treatment appointments for Resident 36. Staff D stated that none of their residents while in their care were able to do chemotherapy and they could not accommodate. Staff D stated there was no expected discharge date for the resident and no appointments were scheduled Review of CC5, Home and Community Services staff's note dated [DATE] at 10:01 AM, documented Resident 36 were told by the facility that they could not remain in the facility as they were not able to handle cancer residents with chemotherapy and the resident stated it had to do with transportation. Review of CC5's note dated [DATE] at 11:41 AM, documented CC5 was told by three different staff in the facility directly that Resident 36 could not remain in the facility if the resident wanted to continue with the chemotherapy due to the facility not having a private room and being to handle the radiation in their body. It documented that Resident 36 had not stated their choice of going to Adult Family Home and the resident's first choice would be to remain in the facility and have their chemotherapy. In an interview on [DATE] at 10:20 AM, Staff D stated they did not schedule appointments or make transportation for residents who required chemotherapy. Staff D stated while the resident in the facility they could not have chemotherapy due to quarantine and need for a private bathroom. Staff E, Registered Nurse/RCM stated the admission coordinator always talked with the hospital case manager so they know that the facility could not do chemotherapy while the resident in the facility. In an interview on [DATE] at 10:24AM, Staff F, admission Coordinator, stated when Resident 36 admitted to the facility, they communicated with the oncologist to pause the chemotherapy and to reestablish treatment after they discharged from the facility. Staff F stated the reason they needed to pause the chemo was due to precautions needed (a private room and bathroom) and the resident was currently residing in a three-person shared room without a private bathroom. In an interview on [DATE] at 10:59 AM, Staff A, Administrator stated they were waiting for the oncology (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505407	A. Building B. Wing	01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Rehabilitation and Care Center	5925 47th Avenue NE Marysville, WA 98270

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	clinic to call and schedule an appointment for a port placement. Staff A stated the resident did not want to go through full treatment and did not want to go out of the building to any appointments prior to [DATE]. Staff A stated the facility had been monitoring labs as requested by the Resident 36's oncologist and they went to the oncologist appointment on [DATE] with their daughter. In a follow up interview on [DATE] at 11:32 AM, Resident 36 stated since admission their plan was to go to chemotherapy appointments and there was never a period of time that they did not want to go to chemotherapy or any other appointment. Resident 36 stated their daughter had died years ago and they had not taken them to any appointments. Resident 36 stated they were not aware of the facility cancelling their chemo appointments and the facility kept telling them they could not provide transportation and could not take care of them after receiving chemotherapy treatments. In an interview on [DATE] at 2:20 PM, CC2 (Scheduler at oncology clinic) and CC6 (Scheduling Supervisor at oncology clinic) stated they called the facility to schedule a port placement for Resident 36, and they were told by Staff D, the facility could not accommodate someone who was receiving chemotherapy. In an interview on [DATE] at 12:53 PM, Staff C, Licensed Practical Nurse (LPN)/Resident Care manager (RCM) stated Resident 36 went to the oncology appointment on [DATE] and they were still waiting for the oncology clinic to send the port placement appointment. Staff C stated they had not yet heard anything from the clinic, and they had not followed up with the clinic. Staff C stated they were not aware of any appointments being cancelled and they were not aware Resident 36 had wanted to go chemotherapy. In an interview on [DATE] at 2:44 PM, CC3 stated Resident 36 had not received any chemotherapy treatments while residing in the facility. CC3 stated they had reached out to the facility multiple times to schedule appointments, but the facility did not assist them, and they even had trouble getting calls back from the facility. CC3 stated the facility told them Resident 36 was not allowed to have chemotherapy when they were in the facility, and the facility could not provide care or transportation for chemotherapy. CC3 stated they had made multiple attempts to call the facility to schedule port placement after the appointment on [DATE] but nobody answered the phone. CC3 stated they wanted to know when Resident 36 would be discharged as they had already been told the facility could not accommodate them with port care. CC 3 stated the facility canceled all appointments for Resident 36's chemotherapy appointments between July and [DATE] and it wasn't until they were admitted to the hospital on [DATE] that they received chemotherapy treatment. CC3 stated the oncology clinic staff attempted to schedule additional chemo appointments after the resident was readmitted to the facility on [DATE] but the facility declined and reported there was no transportation available after 4:00 PM. CC3 stated they rescheduled the appointment for the morning time but the resident did not show for the appointment on [DATE] and the clinic was not notified of the reason. In an interview on [DATE] at 3:51 PM, Staff A stated Resident 36 did not go to any chemotherapy or oncology appointments because the resident admitted to the facility to get rehabilitation therapy to improve their strength before they received chemotherapy treatments. Staff A stated the hospital provider placed rehab therapy before the resident could receive further chemotherapy. Review of the hospital record provided by Staff A, dated [DATE], contained no documentation that the provider ordered to postpone or cancel Resident 36's chemotherapy, rather documented they discussed with Resident 36 and their child about the treatment plan which included chemotherapy every 21 days for the initial three days and consisted of six cycles up to six months. In an interview on [DATE] at 3:51 PM, Staff A stated there was care conference with Resident 36 could not discharge on [DATE] and to schedule chemotherapy after discharge. Review of the occupational therapy (OT) treatment note provided by Staff A, dated [DATE], documented Resident 36 reported plan to discharge on [DATE] due to upcoming chemo treatment and likely to regress with chemo, and Resident 36 was concerned about complete chemo treatment. When asked if Resident 36 went any chemotherapy after [DATE], Staff A stated the facility communicated with the oncology clinic, but the clinic never attempted to schedule chemotherapy, and the resident received chemotherapy in the hospital when admitted on [DATE] due (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505407	A. Building B. Wing	01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Rehabilitation and Care Center	5925 47th Avenue NE Marysville, WA 98270

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to critical and abnormal laboratory results. When asked why Resident 36 could not receive chemotherapy prior to hospital admission or after being readmitted to the facility since [DATE], Staff A stated the resident had terminal cancer. When asked if Resident 36 wanted to receive chemotherapy treatments, Staff A again stated the resident had terminal cancer. In an interview on [DATE] at 9:23 AM, CC5 stated that besides Resident 36, there were three different staff (two facility social workers and one business officer) who told them the resident could not stay in the facility for chemotherapy and the facility could not accommodate residents with chemotherapy and could not provide transportation. CC5 stated they were told the facility had no private bathroom and could not handle urine accommodated with the chemotherapy treatment and Resident 36 had to choose between receiving chemotherapy and being discharged . CC5 stated Resident 36 did not want to leave the facility but they had to leave because the resident wanted to have chemotherapy. CC5 stated Resident 36 got overwhelmed and the resident had to believe what the facility told them. In an interview on [DATE] at 6:40 PM, CC4, Resident 36s family member stated the resident was told after admission to the facility, that they could not receive any chemotherapy because the facility was not equipped or not certified or not qualified to take care of residents receiving chemotherapy and they were not able to take care of residents when they came back. CC4 stated Resident 36 was supposed to have six cycles of chemotherapy over six months and was supposed to have completed those six treatments by now. CC4 stated Resident 36 always wanted to receive chemotherapy and the resident pursued but the facility just told them they could not send them. CC4 stated the facility let the resident believe they could not return to the facility after chemotherapy treatments, that was why the resident should schedule their chemotherapy after they discharged from the facility.In an additional follow up interview on [DATE] at 1:55 PM, Resident 36 stated they had not received permission to cancel their chemotherapy appointments while at the facility. Resident 36 stated they required chemotherapy treatments when they were admitted to the facility since [DATE] and they had not received any chemotherapy while they resided in the facility. Resident 36 stated I was told three times while at the facility I was not allowed to have chemotherapy, that there was no transportation and they could not care for me after my chemotherapy. Resident 36 stated they were confused as to why they could not have chemotherapy and remain at the facility. Resident 36 stated the oncologist had planned for six chemotherapy treatments, comprised of three days in a row and off 21 days and the only time they had received treatments were the two times they were admitted to the hospital. Resident 36 stated their wishes were to have their chemotherapy treatments and when asked if they ever declined the resident stated, I'm not a dummy I wanted to get that over with, they were frustrated that they could not get their treatments, stating This is my life. 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
	505407	A. Building B. Wing	01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Rehabilitation and Care Center	5925 47th Avenue NE Marysville, WA 98270

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 interview and record review the facility failed to ensure residents received the necessary care and services to attain or maintain their highest practicable level of well-being for 2 of 2 residents (Resident 82 and 94) reviewed for quality of care. These failures placed all residents at risk of developing wounds, worsening wounds and other skin conditions and diminished care. Findings included.<COMPRESSION STOCKINGS>Resident 82 admitted to the facility on [DATE] with diagnoses to include history of stroke, history of falling, and orthostatic hypotension (a form of low blood pressure that happens when standing after sitting or lying down). Review of Resident 82's Medication Administration Record (MAR) from 01/01/2026 through 01/06/2026 showed a physician's order dated 01/02/2026 directing nursing staff to apply compressing stockings to both their lower extremities in the morning and remove at night for orthostatic hypotension. During an observation on 01/06/2026 at 11:48 AM Resident 82 was observed lying in their bed, their legs uncovered with no compression stockings. During an observation on 01/07/2026 at 9:41 AM Resident 82 were observed lying in their bed, their legs uncovered with no compression stockings. In an interview on 01/08/2026 at 4:15 PM Staff M, Registered Nurse, stated Resident 82 wore compression stockings for orthostatic hypotension. When asked if Resident 82 was wearing compression stockings, Staff M entered the resident's room and asked to see their legs. Resident 82 was wearing protective sleeves, loose fitting, and bunched up around their ankles. Staff M stated Resident 82 was wearing skin protective covers rather than compression stockings. Staff M searched Resident 82's room for compression stockings, none were found. Resident 82 stated they would get some compression stockings for them. Review of Resident 82's progress notes, dated 01/02/2026 through 01/08/2026 showed no documentation of refusals to wear compression stockings. <SAGE BOOTS>Resident 94 admitted to the facility on [DATE] with diagnoses to include multiple pressure wounds and failure to thrive. Review of Resident 94's discharge summary from the hospital dated 01/02/2026 documented that they were to wear sage boots (heel protection boots for pressure relief) to both their feet to offload (relieve pressure) their heels. Review of Resident 94's Treatment Administration Record (TAR) documented a physician order dated 01/07/2026 for daily and as needed heel protectors at all times one time a day for wound care. Review of Resident 94's care plan dated 01/02/2026 documented they had heel and ankle ulcers with interventions to include foam boots as tolerated for wound healing. During an observation on 01/06/2026 at 9:56 AM Resident 94 was observed lying in bed, foam boots at the foot of the bed, and not worn. During an observation on 01/07/2026 at 9:13 AM Resident 94 was observed lying in bed, foam boots at the foot of the bed, and not worn. In an interview on 01/07/2026 at 9:40 AM Resident 94 stated a someone had walked through their room and made the comment that they should be wearing their boots all the time. In an interview on 01/08/2026 at 1:42 PM Staff N, Nursing Assistant Certified, stated they rely on the care plan and information from other staff to care for residents in the facility. Staff N stated Resident 94 had boots for their feet and were to wear them at night, but it was up to the resident if they wanted to wear them. In an interview on 01/12/2026 at 10:20 AM Staff B, Director of Nurses, stated there was a physician order for Resident 94 to wear foam boots starting 01/02/2026. Staff B stated there were no documented refusals for Resident 94 to wear the foam boots. Reference WAC 388-97-1060(1)(3)(c)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505407	A. Building B. Wing	01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Rehabilitation and Care Center	5925 47th Avenue NE Marysville, WA 98270

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure developed interventions (fall mats and call lights) were in place to minimize the risk for injury during a fall for 1 of 2 sampled residents (Residents 26) reviewed for accident hazards. This failure placed residents at risk for potential injury, negative outcomes and decreased quality of life.Findings included .Review of the facility policy titled, Fall Best Practice Guidelines dated 3/2016 documented the facility would:* Identify an action plan or approaches to be taken to prevent further falls based on newly identified facts or risk factors.* Update the resident Care Plan to reflect new action plans or approaches to prevent new falls. * Update resident care guide. * All residents will be reviewed at a minimum of two additional time by the fall intradisciplinary team weekly meetings to assess and document in the medical record whether the intervention had been successfully implemented or if further recommendations were required. Resident 26 admitted to the facility on [DATE] with diagnoses to include vascular dementia (a decline in thinking skills from reduced blood flow to the brain), history of falls, and leg fracture.Review of Resident 26's incident reports related to falls documented:- On 07/15/2025 fall documented on the Kardex (guide derived from the care plan directing staff on how to care for a particular resident), dated 07/22/2025, Resident 26 required fall mats at bedside. Resident 26 was educated on the importance of using their call light for assistance.- On 07/21/2025 fall documented on the Kardex, dated 07/24/2025, Resident 26 required fall mats at their bedside.- On 09/03/2025 fall documented on the Kardex, dated 09/09/2025, Resident 26 required fall mats at their bedside.- On 09/28/2025 fall documented on the Kardex, dated 10/01/2025, Resident 26 required fall mats at their bedside. Resident 26 was educated on the importance of using their call light for assistance.Review of Resident 26's care plan on 01/08/2026 documented they were a fall risk. Interventions included maintaining Resident 26's bed in a low position, anticipating their needs, ensuring the call light was within reach and floor mats at the bedsideDuring an observation on 01/05/2026 10:37 AM, no floor mats were observed at Resident 26's bedside. Observed Resident 26's call light laying on the floor behind their bed out of their reach.During an observation on 01/06/2026 at 1:59 PM and 01/07/2026 at 10:01 AM, Resident 26 was observed lying in their bed with no floor mats at their bedside.During an observation on 01/08/2026 at 1:15 PM, Resident 26 was observed lying in their bed, their meal in front of them on an overbed table, their call light out of reach on the floor, and no floor mats at their bedside.During an observation on 01/09/2026 at 11:28 AM, Resident 26 was observed lying in their bed, their call light out of their reach, draped over their wheelchair several feet away from the bed.In an interview on 01/07/2026 at 11:42 AM Staff O, Nursing Assistant stated they know how to care for residents by reviewing their Kardex and care plan in addition to obtaining information from therapy or the nursing staff. When asked if Resident 26 was a fall risk, Staff O stated they had not worked with them for a while and they did not have the strength to get up anymore.In an interview on 01/09/2026 at 2:16 PM Staff Q, Nursing Assistant Certified (NAC) stated Resident 26 required two-person assistance for transfers, becomes agitated and annoyed and required a calm approach. Staff Q stated Resident 26 was a fall risk just by the way they maneuvered their body while in bed. When asked what fall interventions were in place for Resident 26, Staff Q stated their bed was in the low position. Staff Q stated they had worked for the facility for 2 months and had not seen Resident 26 with fall mats at their bedside.In an interview on 01/09/2026 at 11:28 AM Staff P, NAC stated Resident 26 was moved a lot in the last several months and they may have had fall mats in the other rooms. Staff P stated Resident 26 was no longer a fall risk given increase in their pain and not using their wheelchair anymore.In an interview on 01/08/2026 at 2:54 PM Staff A, Administrator, stated the clinical resource manager had been in the facility the day before and discontinued Resident 26's intervention for fall mats at bedside. Staff A stated the intervention was a (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505407	A. Building B. Wing	01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Rehabilitation and Care Center	5925 47th Avenue NE Marysville, WA 98270

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	year old and it should have been resolved a while ago. When asked how and when the fall mats were determined no longer appropriate, Staff A did not provide a response.Reference WAC 388-97-1060 (3)(g)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505407	A. Building B. Wing	01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Rehabilitation and Care Center	5925 47th Avenue NE Marysville, WA 98270

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 observations and interviews, the facility failed to ensure treatment carts and medication carts were locked for 1 of 1 treatment carts (Treatment Cart 1) and 1 of 4 medication carts (Medication Cart C). These failures placed residents at risk for having access to treatment supplies and medication not prescribed to them, missing medication, and access to medication by unauthorized individuals. Findings included .<Unlocked Medication Cart C>On 01/05/2026 at 11:55 AM Medication Cart C was observed unlocked and unattended. Staff R, Registered Nurse, was observed to enter room [ROOM NUMBER]. Several facility staff walked by Medication Cart C while unlocked and unattended. Staff R returned to Medication Cart C at 11:58 AM.In an interview at 11:55 AM Staff R stated they had not realized their medication cart was left unlocked and locked the cart. Staff R stated the expectation was to have their medication cart locked when unattended to prevent anyone from taking medication and misusing it. <Unlocked Treatment Cart 1>On 01/09/2026 at 11:17 AM Treatment Cart 1 was observed to be unlocked. The top drawer of the treatment cart contained antifungal cream tubes, alcohol preparation pads, and prescribed wound gel for a resident. The second drawer contained spray wound cleanser, the third drawer contained tweezers and wound supplies (pads, dressing supplies), The fourth drawer contained bottles of iodine, gloves, and sanitizing wipes.In an interview on 01/09/2026 at 11:20 AM Staff S, Licensed Practical Nurse, stated they had not recently used the treatment cart, did not know that it was unlocked, and that it should be locked after use. Staff S locked the treatment cart.Reference WAC 388-97-1300 (2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505407	A. Building B. Wing	01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Rehabilitation and Care Center	5925 47th Avenue NE Marysville, WA 98270

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to identify the resources needed and provide the necessary care and services the resident requires during day to day operations according to the facility assessment (document describing resident population and needs to determine staff and other resources necessary to competently care for residents). The facility failed to provide care and treatment for chemotherapy for 1 of 1 resident (Resident 36). This failure placed residents at risk of unmet medical needs and delays in care, treatment and service needs. Findings included.Review of the facility's policy titled, Facility Assessment, 2025/2026, revised date 08/22/2025, documented the facility is licensed to provide care for 82 residents. The actual maximum number of residents allowable may be less at times to accommodate for safe resident care needs (e.g., infection isolation). The facility assessment documented Services and Care we offer based on Residents' needs included Cancer Treatments (Chemotherapy/Radiation).<RESIDENT 36>Resident 36 admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include malignant extensive stage lung cancer (end stage lung cancer has spread to other parts of the body) and metastasis to liver (cancer has spread to the liver). According to the quarterly Minimum Data Set (MDS-an assessment tool) assessment, dated 11/27/2025, documented Resident 36 was cognitively intact. Review of a hospital consultation note dated 07/10/2025 at 9:44 PM, documented Resident 36's chemotherapy treatment would consist of six cycles of chemotherapy up to six months, which could be given every 21 days for the initial three days of the cycle.In an interview on 01/05/2026 at 1:49 PM, Resident 36 stated they were supposed to have chemotherapy, but the facility told them they did not take care of residents or provide transportation for residents who required chemotherapy. In an interview on 01/07/2026 at 2:43 PM, Resident 36 stated they were not aware they could not do chemotherapy before being admitted to the facility and they always wanted to get their chemotherapy. Resident 36 stated they were not aware the facility canceled their chemotherapy appointments. In an interview on 01/08/2026 at 9:15 AM, Collateral Contact (CC) 1, Resident 36's Caregiver, stated the facility had not allowed the resident to have chemotherapy or have port placement since admitted to the facility in July 2025. CC1 stated the facility informed them that the nurses in the facility could not take care of a port or take care of Resident 36 when they returned from chemotherapy treatments. In an interview on 01/07/2025 at 10:20 AM, Staff D stated they did not schedule appointments or make transportation for residents who required chemotherapy. Staff D stated Resident 36 could not have chemotherapy while residing in the facility due to the need for quarantine and a private bathroom.In an interview on 01/07/2026 at 10:24AM, Staff F, admission Coordinator, stated when Resident 36 admitted to the facility, they communicated with the oncologist to pause the chemotherapy with the plan to resume after they discharged . Staff F stated the reason they needed to pause the chemotherapy was due to the required precautions and given Resident 36 was residing in a three-person shared room without a private bathroom they were unable to accommodate treatments. In an interview on 01/08/2026 at 2:44 PM, CC3, RN at oncology clinic stated the facility told them Resident 36 was not allowed to have chemotherapy while residing in the facility and could not provide care or transportation for chemotherapy. In an interview on 01/11/2026 at 6:40 PM, CC4, Family member of Resident 36 stated the resident was told after admission to the facility that the resident could not receive any chemotherapy because the facility was not equipped, not certified and not qualified to take care of residents who required chemotherapy. In an interview on 01/13/2026 at 9:23 AM, CC5, Home and Community Services Social Worker stated there were three different staff (two facility social workers and one business office) who told them the Resident 36 could not stay in the facility for chemotherapy, could not accommodate residents with chemotherapy (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505407	A. Building B. Wing	01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Rehabilitation and Care Center	5925 47th Avenue NE Marysville, WA 98270

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and could not provide transportation. CC5 stated they were told by facility staff they had no private bathrooms and could not handle urine accommodated with the chemotherapy treatment and Resident 36 had to choose between receiving chemotherapy and being discharged . In an interview on 01/08/2026 at 3:51 PM, Staff A stated the facility would arrange transportation, make appointments and provide care for residents who wanted chemotherapy.No associated WAC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505407	A. Building B. Wing	01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Rehabilitation and Care Center	5925 47th Avenue NE Marysville, WA 98270

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a system in which resident's records were complete, accurate, and accessible, for 1 of 1 resident (Resident 36) reviewed for accurate and complete medical records. The facility failed to ensure the residents' medical records contained weekly laboratory results and accurate documentation about appointments placed residents at risk for medical complications, unmet care needs, and for diminished quality of life. Findings included .<APPOINTMENTS>Review of an oncology clinic note dated 10/16/2025 at 11:04 AM, documented Resident 36 scheduled an appointment on 10/29/2025 at 2 PM. Review of the facility providers' notes dated 10/21/2025 at 9:39 AM, 10/24/2025 at 8:52 AM, documented to follow up with oncologist (cancer specialist) on 10/29 at 2 PM.Review of an oncology clinic note dated 10/29/2025 at 2:24 PM, Resident 36 was no show for the visit, and the clinic was not notified of the reason.Review of Resident 36's Electronic Medical Record (EMR) on 10/29/2025 showed no documentation about if Resident 36 attended the appointment or what the reason of missing the appointment was. In an interview on 01/08/2026 at 12:53 PM, Staff C, Licensed Practical Nurse/Resident Care Manager, stated Resident 36 had an appointment on 10/29/2025 and the resident went but there was no documentation.In an interview on 01/07/2026 at 10:59 AM, Staff A, administrator, stated they would ask the nurse about if Resident 36 went for the appointment.On 01/08/2026 at 5 PM, Staff A provided two staff statements by Staff D, Receptionist and Staff H, Licensed Practical Nurse, dated 01/08/2026, documented that on 10/29/2025, Resident 36 canceled the appointment themself due to not feeling well, this information was not documented in the resident's clinic record.In multiple interviews on 01/07/2026 at 2:43 PM, 01/08/2025 at 2:33 PM, and 01/09/2026 at 1:55 PM, Resident 36 stated they never canceled appointment themselves, and they were not aware of the appointment was cancelled. Resident 36 stated they always wanted to go for appointments to get their cancer treated. <LABORATORY RESULTS>Resident 36 admitted to the facility on [DATE] with diagnoses to include malignant extensive stage lung cancer (end stage lung cancer has spread to other parts of the body), metastasis to liver (cancer has spread to the liver). According to the quarterly Minimum Data Set (MDS-an assessment tool) assessment, dated 11/27/2025, the resident was cognitive intact.Review of Resident 36's January 2026 Medication Administration Record (MAR), documented a physician order of weekly laboratory. Review of Resident 36's laboratory results in Electronic Medical Record (EMR), no laboratory results found from 10/24/2025 to 11/19/2025, and from 11/21/2025 to 12/18/2025.In an interview on 01/12/2026 at 12:35 PM, Staff G, Medical Record Director, stated all laboratory results were uploaded to EMR.In an interview on 01/12/2026 at 12:40 PM with Staff C, Licensed Practical Nurse/Resident Care Manager (RCM), and Staff B, Director of Nursing, Staff C stated they would look for the laboratory results during the above time periods. No further information provided. Reference WAC 388-97-1720 (1)(a)(i)(ii)(iii)(iv)(2)(l)