STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505185	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Olympic View Care	1116 E Lauridsen Boulevard Port Angeles, WA 98362

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45203 Based on interview and record review, the facility failed to provide care in a manner that promoted respect and dignity for 2 of 5 residents (2, 3) reviewed for dignity and respect. This failure placed residents at risk for unmet needs, diminished self-worth, and continued episodes of disrespect. Findings included . Review of the facility policy, titled Resident Rights, dated 08/2022, showed the purpose was to treat each resident with dignity and respect, and in a manner that promotes maintenance or enhancement of self-esteem. Review of the Facility Grievance Log from 09/25/2024 to 10/25/2024 showed five entries from five different residents. All five entries were related to how staff treated or spoke to residents. The log showed: On 09/26/2024, a resident reported between the hours of 8pm and midnight, a staff member was unkind to him when he requested a blanket. The facility summary report showed the resident had dementia and could not identify a staff member or recall the incident. Staff reported there were no problems. The resident was made, care in pairs. On 09/30/2024, a resident reported they felt uncomfortable with the care and speech from a staff member. The grievance form identified Staff F as yelling at the resident and being rude, and not listening to the residents' needs and felt that Staff F should not have been working in that setting. The facility summary report showed the staff member felt they provided proper care, and the staff member would no longer be assigned to provide care to the resident. <Resident 2> Resident 2 was admitted to the facility on [DATE]. The admission minimum Data Set (MDS), and assessment tool, dated 10/12/2024, documented Resident 2 was cognitively intact. (continued on next page)

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

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/25/2024 at 2:43pm, Resident 2 said that one evening her call light was on for over 35 minutes, when she went to the nurses station she found that Staff F, Nursing Assistant, was at the nurses station on the phone, Staff F came to her room [ROOM NUMBER] minutes later, Resident 2 requested ice in a bag and Staff F told her she was using too many bags and to untie and reuse the one she had. Resident 2 said she reported the concern to Staff C, who told her there were multiple reported concerns regarding Staff F. Review of the Grievance log from 09/25/2024 through 10/25/2024 showed an entry for Resident 2 that documented: On 10/11/2024, Resident 2 reported they felt a staff member was not a good fit for caring for residents. Review of the Facility Grievance Form showed Resident 2 reported that night shift staff did not respond to her call light for 45 minutes and when she went to the nurses' station staff told her they would help her after they finished eating their apple, that they had not started eating yet. The facility summary showed there was no identified caregiver and night shift was spoken to as a whole about being nice to the residents. <Resident 3> Resident 3 was admitted to the facility on [DATE]. The admission MDS, dated [DATE], documented Resident 3 was cognitively intact. A complaint intake, dated 10/16/2024 at 1:46pm, showed it was reported that on 10/15/2024 facility staff had treated Resident 3 rough during care and when the resident reported it hurt, the staff member told her she should have moved faster. Review of the Grievance Log from 09/25/2024 through 10/25/2024, showed an entry for Resident 3 that documented: On 10/18/2024 Resident 3 reported the NAC was rough when moving her leg. The facility grievance summary report showed the caregiver gave her statement and would no longer be assigned to provide care to the resident. On 11/07/2024 at 2:59 pm, Staff C, Licensed Practical Nurse, Resident Care Manager (RCM), said she knew Resident 2 filled out grievance forms and did not like the way she was treated. Staff C said she did not recall if there were other reported concerns regarding Staff F. Staff C said she was not aware of other resident reports regarding treatment from staff. Staff C said they could not recall when the last Inservice regarding resident rights or respect and dignity was and had attended an in-service held earlier that day. On 11/08/2024 at 3:17pm, Staff E, Social Services Director, said he did not recall when the last in-service on resident rights or respect and dignity was. He had attended the all-staff meeting the day before. He was not aware of multiple resident reports of being treated with less than dignity and respect within a 30-day period. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 4:05pm, Staff A said there were multiple grievance regarding Staff F, and she spoke to her about how she talks to people and changed her schedule. There was no written record of this. Staff A said they talk about the grievances at the morning stand up meeting and she is trying to address it and get staff to respond kindly. Staff A was not able to provide documentation that staff education was provided as a group or individual following multiple reported concerns by residents over a 30-day period of time. At 4:15pm, Staff B said she was aware of some of the grievances but not specifics, she was not aware of multiple residents reporting concerns regarding Staff F and had not identified a concern of multiple resident reports of being treated without dignity and respect. Reference WAC 388-97-0860(1-2)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45203 Based on observation, interview and record review, the facility failed to consistently provide care and services as ordered for non-pressure wounds for 1 of 5 residents (1) reviewed for quality of care. This failure placed residents at risk for worsening wounds, infection, and decreased quality of life. Resident 1 was admitted to the facility on [DATE]. The Admission Minimum Data Set (MDS), an assessment tool, dated 10/19/2024, documented the resident was cognitively intact, medically complex and had an infection and non-pressure wounds of the foot, requiring dressings. The care plan focus for right lower ulcer with gangrene (a serious condition that occurs when body tissue dies due to a lack of blood flow or a bacterial infection), initiated on 10/14/2024, included interventions to treat wound as per MD orders. A physician's order, dated 10/12/2024, instructed staff to paint all toes and gangrene [of right foot] with 10% provodine/iodine, let dry, cover with non-adherent gauze and secure with roll[ed] gauze daily and as needed. A physician's order, dated 10/12/2024, instructed staff to cleanse the right lateral (outer) and medial (inner) ankle with normal saline and gauze, pat dry, and sure prep to skin around wound, apply iodasorb gel to wound bed, cover with non-woven gauze, and secure with roll gauze, change every three days and as needed for 50% soilage/breakthrough drainage or dislodgement. Review of Resident 1's October 2024 Treatment Administration Record showed no documentation that wound care to the right gangrenous toes was provided on 10/15/2024, 10/19/2024, 10/23/2024, 10/24/2024, and 10/25/2024. There was no documentation that wound care was provided to the lateral and medial ankle on 10/19/2024 and 10/25/2024. On 10/29/2024 at 9:05am, Family Member (FM)1 said they had visited Resident 1 on 10/26/2024 and noted daily dressings had not been done, they reported the concern to the nursing assistant. On 10/31/2024 at 3:46 pm, Resident 1's FM 2 said daily dressings were not being done. During observation of wound care, the dressing to the right foot was observed and an area of approximately 10 centimeters of light brown drainage soaked through the medial (inner) ankle and an incontinence brief had been placed around the dressing. The great toe and second, third and fourth toes of the right foot were black and necrotic (gangrenous), without odor noted. Staff C assisted with wound care and confirmed ankle wound care was to be performed every three days and the toes were to be dressed daily. Review of Resident 1's November 2024 Treatment Administration Record from 11/01/2024 through 11/06/2024 showed no documentation that wound care to the right gangrenous toes was provided on 11/01/2024 and 11/03/2024. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/07/2024 at 2:59 pm, Staff C, Licensed Practical Nurse, Resident Care Manager, said if dressings were ordered to be changed daily, she would expect them to be changed and documented daily. Staff C said she was aware of the omission and spoke to the nursing staff about it. Staff C said if staff were unable to complete the dressing due to a medical appointment or the resident not being at the facility during the day, she would expect the night shift to do it. At 6:32pm, Resident 1's FM 3 said they observed Resident 1 on multiple occasions at his 5:00pm dialysis appointment with dressings that had not been changed that day or the day before. They said there was frequently drainage visible. On 11/08/2024 at 1:58pm, CC 1 said during the first two weeks of service, Resident 1 would frequently arrive to his appointments with drainage seeping through the dressing. At 4:13pm, Staff B, Registered Nurse, Director of Nursing, said she believed the nurses were overlapping the dressings and recently clarified the orders, but if it was ordered daily, she would expect it to be done and documented daily. Reference WAC 388-97-1060 (1)