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	01/13/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 45203 Based on observation and interview the facility failed to maintain a safe, clean and comfortable environment through maintenance of the hallway carpets for 3 of 3 halls (East, Mid, and [NAME] B) observed. This failure has the potential to place residents at risk for not having a clean, homelike environment and a diminished quality of life. Findings included . On 12/17/2024 at 3:27 PM, it was reported a family member for a resident had removed resident from the facility because the facility was found to be dirty, filthy, and gross and the carpets were not cleaned or vacuumed, and there was a bad odor. On 12/31/2024 at 1:44 PM, Collateral Contact 1 said the building was a mess and was run down. On 01/09/2025 between 12:24 PM, and 12:30 PM, the following were observed in the East Hall: - Mostly brown and some pink stains in front of rooms 1 through 3 - Scattered debris of small white pieces of paper and plastic - [NAME] matter smeared into the carpet measuring approximately 1 by 2 inches outside of room [ROOM NUMBER] - Dark brown stain on the left side of the doorway for room [ROOM NUMBER] measuring approximately 12 by 3 inches. - Dark, brown stain measuring approximately 8 by 8 inches outside of room [ROOM NUMBER] - Dark, brown stain measuring approximately 6 by 8 inches outside of room [ROOM NUMBER] - Small, dark stains, too numerous to count outside of East Hall nurses' station At 12:34 PM, the following were observed in the Mid Hall: - Too numerous to count stains between rooms 11-24 (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
	505185	A. Building B. Wing	01/13/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Dark stain to left side of doorway measuring approximately 10 by 12 inches outside of room [ROOM NUMBER] - Stains also noted outside of rooms 16, 18, 19, 20, and 22. At 12:39 PM, the following were observed in the [NAME] B Hall: - multiple small dark stains outside of rooms 26, and 28. - reddish brown substance smeared on carpet, measuring approximately 1 by 2 inches outside room [ROOM NUMBER] On 01/13/2025 at 11:32 AM, the following were observed outside the East Hall: - Stain outside of staff training room measuring approximately 12 by 24 inches - Multiple small dark stains in hall between rooms [ROOM NUMBERS]. - Stain outside room [ROOM NUMBER] measuring approximately 9 by 7 inches and scattered bits of pieces of white material, resembling tissue. - Outside of medical supply room door, near East Nurses Station, multiple dark brown stains with the largest measuring approximately 4 by 6 inches. At 11:37 AM, the following were observed in the Mid Hall: - dark brown stain, measuring approximately 10 by 16 inches, on the right side of the hall, between rooms [ROOM NUMBERS] - gray matter smeared on ground approximately 2 by 3 inches outside of doorway of room [ROOM NUMBER] - multiple small scattered dark stains and scattered bits of debris outside rooms 16-24 - multiple white drip stains between room [ROOM NUMBER] and 24. At 1:15 PM, Staff F, Housekeeping staff, said the carpets did not represent a clean home-like environment, but the facility was supposed to get new flooring. At 1:16 PM, Staff G, Housekeeping Assistant, said they cleaned the carpets weekly, and would be increasing cleaning to twice weekly. Staff G said they did not document when the carpets were cleaned. Staff G said they tried to maintain the carpet, but the age of the carpet showed. Staff G said the flooring was supposed to be replaced. Staff G said the current flooring did not represent a clean and home-like environment. At 2:07 PM, Staff B, Registered Nurse and Director of Nursing Services, said they were not sure how often the carpets were cleaned; they would prefer them to be cleaner. Staff B said some flooring was replaced but then it stopped, and they were not sure when the remaining would be replaced. (continued on next page)

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	01/13/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 2:23 PM, Staff A, Administrator, said carpets were cleaned weekly but there was no specific day. Staff A said there was no documentation available to show when carpets were cleaned. Staff A did not know when they were last cleaned. Staff A said the carpets did not represent a clean home-like environment; they had been trying to get the flooring replaced. Reference WAC 388-97-0880

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	01/13/2025

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 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 interviews and record review, the facility failed to ensure services provided met professional standards of practice for 1 of 4 sampled residents (Resident 1) reviewed for quality of care when facility staff 1. failed to assess, monitor and/or document resident responses to interventions on a daily basis for newly admitted residents receiving skilled services and 2. failed to obtain and document vital signs for residents at risk for sepsis (a life-threatening condition that occurs when the body's immune system has an extreme response to an infection. It can lead to organ failure, shock, and death). These failures placed residents at risk for rehospitalization , health complications, and decreased quality of life. Findings included . The facility policy titled, Documentation, revised on 05/12/2023, showed frequency of documentation was dictated by the clinical needs of the resident, as well as state and federal requirements. Nursing documentation should be found in the medical record and included assessments, narrative notes, and vital signs. According to, Lippincott Manual of Nursing Practice (11th ed., pp. 936-964), Sepsis is characterized by a systemic inflammatory response in the presence of suspected or confirmed infection. Symptoms would include increased body temperature, heart rate and respirations and decreasing blood pressure and urinary output. The resident may also present with decreased level of consciousness, confusion, anxiety or agitation. Resident 1 was admitted to the facility on [DATE]. The Medicare 5-day Minimum Data Set (MDS), an assessment tool, dated 11/13/2024, documented Resident was cognitively intact, had an indwelling catheter (tube into the bladder to drain urine) and was medically complex. Review of Resident 1's electronic health record (EHR) showed that no vital signs (blood pressure, pulse, respirations, or temp) were obtained on 11/10/2024, 11/11/2024, 11/12/2024, 11/13/2024, 11/4/2024 and 11/15/202. There were no nursing assessment notes documented for Resident 1 on 11/08/2024, 11/09/2024, 11/10/2024, and 11/11/2024. An Alert Note, dated 11/16/2024 at 1:11 PM, showed the resident requested to be transferred to the Emergency Department (ED), the resident was noted to have uncontrollable shaking, staff were unable to obtain vital signs, 911 was called and the resident was transferred to the hospital. A hospital H&P (history and physical) note, dated 11/16/2024, showed the resident had purulent matter (potential evidence of infection) in her Foley (indwelling) catheter, was hypotensive (low blood pressure), tachycardic (fast heart rate), and had abdominal pain. The resident was admitted for sepsis. A facility Admission note, dated 11/22/2024 at 5:28 PM, showed Resident 1 was readmitted back to the facility. (continued on next page)

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	01/13/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 1's EHR showed no vital signs were obtained from 11/23/2024 through 12/10/2024. There were no nursing assessment notes on 11/24/2024, 11/28/2024, 11/29/2024, 11/30/2024, 12/01/2024, 12/02/2024, 12/04/2024, 12/05/2024, 12/08/2024, or 12/09/2024. Review of Daily Skilled Notes for 12/06/2024 and 12/07/2024 showed the notes to be identical but written by Staff D on 12/06/2024 and Staff E on 12/07/2024. The same note was entered again on 12/10/2024 by Staff D. A provider note, dated 12/11/2024, by Provider A, showed Resident 1 was found to be acutely ill, anxious, with rapid breathing and heart rate, and decreased oxygen levels. Staff had reported the resident refused their meds that morning. 911 was called and the resident was transported to the hospital. The Emergency Department Encounter Note, dated 12/11/2024, showed Resident 1 was admitted for sepsis. On 12/31/2024 at 1:44 PM, Resident 1's Family Member (FM1) said regarding the first hospital admission, when they arrived on 11/16/2024 to visit Resident 1, they were found to be screaming and no one came into the room to check her, staff were at the nurses' station but did not come in to help her until FM1 asked them. FM1 said regarding the second hospital admission, staff had informed him when he arrived that day, 12/22/2024, that Resident 1 had not taken her morning medication. FM1 said they had found Resident 1 without covers on and they did not look well, stating, they were kind of in a daze. FM1 said they summoned staff to help and when staff took Resident 1's vital signs and everything was low, staff then called 911. On 01/09/2025 at 11:44 AM, Provider A, Physician's Assistant, said Resident 1 was medically complex, staff had not alerted them that the resident was ill but rather the resident was scheduled for a routine visit that day. Provider A found Resident 1 on 12/11/2024 to be acutely ill, she assessed the resident and alerted staff to call 911. When asked would they expect staff to perform a daily skilled assessment and obtain vital signs on a resident at risk for sepsis, Provider A said they would expect the facility to follow their protocols. On 01/13/2025 at 1:52 PM, Staff E, Licensed Practical Nurse (LPN), said vital signs should be obtained every shift and documented in the resident's record. Staff E said a daily skilled note was assigned and should be in the resident's record. Staff E said it was not usually accepted practice to copy and paste clinical notes. Staff E said they had not received any training on prevention of or recognizing sepsis. At 1:59 PM, Staff C, LPN, Resident Care Manager (RCM), said if a resident readmitted to the facility for sepsis, they would expect a daily skilled note and vital signs to be obtained and documented in the record. Staff C said they had recent in-services but could not recall if they were regarding sepsis. At 2:07 PM, Staff B, Registered Nurse, Director of Nursing, said if a resident was readmitted due to sepsis, they would expect daily skilled nursing assessments and vitals to be documented in the resident's record. Staff A said they covered sepsis in previous month's meeting. Reference WAC 388-97-1620 (2)(b)(ii)