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	03/07/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45203 Based on interviews and record review, the facility failed to thoroughly investigate an injury for 1 of 3 residents (Resident 1) reviewed for accidents. Facility failure to complete thorough investigations placed residents at risk for further falls and injuries, potential abuse, and other negative health outcomes. Findings included . Resident 1 was admitted to the facility on [DATE] with a right hip fracture. The admission Minimum Data Set (MDS), an assessment tool, dated 01/09/2025, showed Resident 1 was cognitively intact. The care plan, initiated 01/06/2025, showed Resident 1 required extensive assistance for bed mobility and transfers with the goal for improved function. The facility incident report, dated 01/26/2025 at 2:00 AM, showed Resident 1 was found on the floor next to her bed. Staff documented the resident was assessed and no injury was found, and the resident was assisted back to bed. It was documented the resident reported pain to her right hip but declined offer of acetaminophen. Documentation did not include how the resident was assisted back to bed. A nursing note, dated 01/26/2025 at 11:32 AM, showed Resident 1 was noted with right hip pain, swelling and shortened right lower limb. The resident was transported to the emergency room for evaluation. A nursing note, dated 01/26/2025 at 5:02 PM, showed Resident 1 was diagnosed with a dislocated right hip and would require manipulation in the surgical unit, to relocate the hip. On 02/24/2025, Resident 1's Power Of Attorney (POA) said Resident 1 told her multiple times that she did not fall out of bed, reporting, I didn't fall, I was thrown into the bed. She kept telling me, He threw me POA said this was reported to staff, but they did not do anything about it. Review of the facility investigation documentation for the incident on 01/26/2025 did not include staff or resident interviews/statements. There was no documented follow up with the resident to determine how the injury occurred. (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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/07/2025, at 3:15 PM, Staff C, Registered Nurse, Resident Care Manager, said during an investigation of a fall, they would interview nursing assistants, nurses, the resident and or their roommate. This information would be included in the packet. At 3:38 PM, Staff A, Administrator, said a facility investigation was expected to include staff interviews and the resident. Staff A said they would see if there was additional information available, as Staff B was not there that day. Reference WAC 388-97-0640 (6)(a)(b)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45203 Based on interview and record review, the facility failed to ensure behavioral health care and services were provided for one of six sampled residents (Resident 2) reviewed for behavioral health services. This failure placed residents at risk for increased behaviors, not receiving necessary services to meet their mental health needs and a diminished quality of life. Findings included . Resident 2 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS), an assessment tool, dated 12/18/2024, showed the resident was cognitively intact, medically complex and had verbal behaviors directed toward others that significantly interfered with the resident's participation in activities and social interactions and intruded on the privacy and activity of others. The care plan focus for behavioral problems, initiated on 11/29/2023 and updated on 03/03/2025, identified the resident had the potential to make sexually inappropriate comments to female residents. Goals for the resident initiated on 11/29/2023 and revised on 03/07/2025, included the resident would accept care from caregivers, have socially appropriate behaviors when conversing with female residents, and have no injury to self or others. Interventions included approach in a calm manner, talk with resident, document behaviors, discuss and reinforce why behavior is unacceptable, intervene as necessary to protect rights and safety of others. A level two PASARR (preadmission screening and resident review) evaluation (a tool used to identify individuals with mental illness) was completed on 09/16/2024. A social services note, dated 12/25/2023 at 11:44 AM, showed Resident 2 had a history for making inappropriate comments towards staff/women about womens' bodies. A social services note, dated 12/27/2023 at 1:45 PM, showed a care conference for Resident 2 with discussion about Resident 2's many sexual and physical abuse moments and how multiple women at [the facility] refuse to be around him. Resident 2's Family member requested Resident 2 see a neurologist. A social services note, dated 01/02/2025 at 9:17 AM, showed Resident 2 was pursuing a housekeeper and trying to grab her and kiss her. When Resident 2 was approached by social services and the housekeeping supervisor, he shouted an expletive at them. A social services note, dated 01/02/2025 at 2:46 PM, showed Resident 2 made an inappropriate sexual comment with physical gestures to a female staff member. On 01/02/2025 at 3:34 PM, Resident 2 returned from appointment with a referral for a neurology consult. A behavioral health provider note, dated 01/07/2025 at 8:30 AM, showed provider was aware of the staff reports of sexually inappropriate behaviors. There were no changes to his treatment plan. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A life enrichment note, dated 01/14/2025 at 3:51 PM, showed Resident 1 was asked to stop touching and kissing a resident's hand and was observed following the female resident when she left the area, necessitating staff intervention. A behavioral health provider note, dated 02/06/2025 at 8:15 AM, showed the resident continued with sexually inappropriate behaviors despite recent medication changes. The note included, staff reports he refused care; he is irritable on assessment. staff report patient continues to make sexually inappropriate comments, touching staff and residents, being aggressive with residents. There were no changes to his treatment plan. An incident note, dated 02/09/2025 at 5:53 PM, by Staff I, Registered Nurse (RN), showed Resident 2 was involved in a resident to staff verbal and physical altercation in which Staff I, was injured, requiring first aid and later medical attention. Local law enforcement was notified. A mood and behavior note, dated 02/09/2025 at 6:00 PM, by Staff J, Licensed Practice Nurse (LPN), showed Resident 2 went on to verbally and physically attack them as they were trying to help Staff I and diffuse the situation. An alert note, dated 02/10/2025 at 12:07 PM, by Staff B, RN Director of Nursing, showed the IDT (interdisciplinary team) determined the resident was no longer in need of skilled services and able to perform Activities of Daily Living (ADLs) independently and manage his medications. Resident 2 was provided with a notice of discharge. Continued behaviors have threatened the safety and health of other individuals, which is why the resident is being handed a discharge notice. A behavioral health provider note, dated 02/18/2025 at 8:30 AM, showed that staff reported physical aggression with staff and was given a notice of discharge due to his ongoing behavior and he has been self-isolating. Resident 2 reported, he did something bad and was given a [30-day discharge notice]. He reported he feels crappy, angry and sad. The note showed he appeared irritable, angry with poor insight to his behavior, stating he didn't do anything wrong. Behavioral interventions were recommended. These interventions were already part of the established careplan. A health status note, dated 02/28/2025 at 3:17 PM, showed the resident had intact cognition, was moderately depressed with thoughts he would be better off dead, denied, self-harm and verbalized frustration with virtual mental health visits, stating they are always during bingo. A social services note, dated 03/03/2025 at 11:35 AM, showed Resident 2 was given a 30-day notice of discharge but there was no discharge plan available. On 02/21/2025 at 10:02 AM, Staff I, Registered Nurse (RN) said Resident 2 had a long history of inappropriate behaviors and he continued to say and do sexually inappropriate things. Staff I said on 02/10/2025 Resident 2 intentionally rammed his wheelchair into her causing an injury to her left heel which required medical attention. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/07/2025 at 12:50 PM, Resident 2 said, regarding his behaviors, he may have said some things he shouldn't have said to the nurse, but he did not intend to hurt her, Resident 2 alleged he was unaware Staff I was behind his chair. Resident 2 said he did not feel his mental health needs were being met, stating, I get a 3-minute telehealth visit every two weeks, she asks me the same questions each time and nothing ever changes, I would prefer to talk to someone in person and I need to see a neurologist. At 1:06 PM, Staff E, LPN, said they were afraid of Resident 2 for herself and the residents, Staff E said there had been no recent resident to resident altercations involving Resident 2, but she witnessed several, maybe 6-8 months ago. Staff E felt residents were at risk due to Reisdent 2's behaviors. At 2:46 PM, Staff D, Social Services Assistant, said Resident 2 had behavioral issues, they have personally been subject to his sexually inappropriate behavior. Staff D said he knows what he is doing is wrong but won't stop the behavior. Staff D said Resident 2 was regularly seen by the behavioral health provider, but he does not always comply. Staff D said they do not have an in person mental health provider. Staff D said she was not aware of any incidents involving other residents. At 3:15 PM, Staff C, RN, Resident Care manager, said the facility had a telehealth mental health provider who serviced the facility two times a month. Staff C said there were no in person services available. Staff C said she was not aware of any residents who see providers in the community. Resident 2 had a long history of making inappropriate sexual comments, getting mad and verbally aggressive to residents and staff, recalling an incident about a month prior where the resident blocked another resident from leaving a common room. Staff C said they protected other residents by being aware of his location at all times, stating he spends a lot of time in his room. Staff C felt Resident 2's behavioral health needs were not being met but it was due to his refusals. Staff C felt other residents were at risk if Resident 2 was left unattended. At 3:40 PM, Staff A, Administrator, said Resident 2 was not appropriate for the facility and has tried to discharge him but there was not a safe plan at the present time. Staff A said there was not a recent resident to resident incident involving Resident 2, rather one female resident voiced they were uncomfortable around him and a previous incident involving Resident 2 blocking a doorway. The resident was assisted out of the room by another door. They protect other residents by watching him and monitoring his behavior. Staff A felt Resident 2's behavioral health needs were being met. Staff A said they did not offer in person mental health services or transport residents to community mental health providers. No Associated WAC