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	04/03/2025

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45203 Based on interviews, and record review, the facility failed to ensure baseline care plans were developed and implemented within 48 hours of admission and included the minimum information necessary to properly care for 4 of 4 sampled residents (Residents 1, 2, 3, and 4) when reviewed for care plans. This failure placed residents at risk for unidentified and/or unmet care needs, negative health outcomes, and a decreased quality of life. Findings included . <Policy> Review of the facility policy titled, Baseline Care Plan Policy, revised 12/2024, showed the facility was to develop a baseline care plan within 48 hours of admission to direct the care team and should include the minimum healthcare necessary to properly care for the resident. <Resident 1> Resident 1 was admitted to the facility on [DATE]. The admission minimum data set (MDS) and assessment tool, dated 02/09/2025, showed Resident 1 was cognitively intact, medically complex and had central line access (also known as a central venous catheter (CVC), a long, thin tube (catheter) inserted into a large vein to provide long-term access for fluids, medications, blood draws, and monitoring). The care plan, initiated 02/04/2025, did not include focus, goals or interventions related to the central line access. The resident discharged from the facility on 03/07/2025. <Resident 2> Resident 2 was admitted to the facility on [DATE]. The admission MDS, dated [DATE], showed Resident 2 was cognitively intact, medically complex and had a feeding tube (a thin, flexible tube inserted through the skin and into the stomach. It is used to provide nutrition and medication when a person is unable to eat or drink normally) on admission. The care plan focus for tube feedings was added on 1/21/2025, 11 days after admission. (continued on next page)

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Resident 3> Resident 3 was admitted to the facility on [DATE]. The admission MDS, dated [DATE], showed Resident 3 was cognitively intact and receiving IV (intravenous -involves delivering fluids, medications, nutrients, or blood directly into a vein, bypassing the digestive system for faster absorption and action) medications, although it did not identify the type of IV access. The careplan initiated on 03/18/2025 showed one focus, for activities of daily living, with no goals or interventions. Review of the updated careplan showed revisions were made on 03/20/2025, 03/22/2025, and 03/28/2025 but did not include interventions related to Resident 3's PICC (peripherally implanted central catheter) to right upper arm. Review of Resident 3's Treatment Administration Record (TAR) showed no interventions for PICC line dressing changes implemented until 03/28/2025, 11 days after admission. <Resident 4> Resident 4 was admitted to the facility on [DATE]. The admission MDS, dated [DATE], showed Resident 4 was cognitively intact, medically complex, and was receiving IV medications, the assessment did not include the type of IV access. The careplan initiated on 3/21 included potential for infection related to PICC line with the goal to not develop signs or symptoms of infection and interventions including to change the IV tubing, notify MD of signs and symptoms of IV infection, notify the nurse of loose dressing or swelling to the area, and the used of enhanced barrier precautions. Review of Resident 4 TAR showed no intervention for PICC line dressing changes implemented until 04/01/2025, 10 days after admission. On 04/02/2025 at 2:33 PM, Staff E, Nursing Assistant (NA), said they know which residents require special precautions for things like feeding tubes and IVs by what is on the Kardex (careplan). For example, residents with a feeding tube, they would keep the head of bed elevated and for IV's they would not do blood pressures on that arm. On 04/03/2025 at 2:06 PM, Staff F, NA said they knew which residents required special precautions for things like feeding tubes and IVs by what was on the Kardex (careplan). For example, residents with feeding tubes they would make sure the tubing was not kinked and/or it was closed and for residents with IV's they would make sure they wore gloves. At 2:30 PM, Staff D, Licensed Practical Nurse, said they knew what interventions were needed for residents by what was listed on the Medication Administration Record (MAR)/TAR. Staff D said the Resident Care Managers (RCM) developed the care plan and the initial orders. Staff D said for residents with feeding tubes they would expect tube site dressing changes and keeping the head of bed elevated. Staff D said for residents with IV's, they would expect dressing changes and orders to monitor the site for infection. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 3:14 PM, Staff C, Registered Nurse (RN), RCM, said the RCM's or Staff B, Registered Nurse, Director of Nursing Services, usually develop the baseline careplans when the resident admits to the facility. They utilize batch orders for things like IVs and tube feeding. Staff C said they would expect interventions necessary for staff to immediately provide care for newly admitted residents. At 3:58 PM, Staff B said she expected the baseline careplan to be established in the first 72 hours. Staff B said she would expect necessary interventions to be included for staff to be able to provide immediate care for newly admitted residents. Staff B was not sure why the baseline care plans were not completed but said, they are usually addressed. See F 684 Reference WAC 388-97-1020 (3)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 interview and record review, the facility failed to provide care and services adequate to prevent hospitalization for 2 of 3 residents (Residents 1 & 2) reviewed for hospitalization . The facility failed to provide central line maintenance for Resident 1 resulting in hospitalization for a potential central line (also known as a central venous catheter (CVC), is a long, thin tube (catheter) inserted into a large vein to provide long-term access for fluids, medications, blood draws, and monitoring) blood infection and failed to adequately monitor Resident 2 (who was receiving nutrition via a feeding tube), following an episode of emesis, resulting in hospitalization for acute respiratory failure with hypoxia. These failures placed residents at risk for infection, hospitalization , and a diminished quality of life. Findings included . Review of the CDC; Guidelines for prevention of intravascular Catheter-related Infections, dated 2011 showed that CVC (central venous catheters) site dressings should be changed every seven days. Review of the facility policy titled, Enteral Feeding/Hydration/Tube Management, revised [DATE], showed staff were to verify the head of bed was raised to ,d+[DATE] degrees for residents receiving tube feeding. Resident 1 was admitted to the facility on [DATE]. The admission minimum data set (MDS) and assessment tool, dated [DATE], showed Resident 1 was cognitively intact, medically complex and had a central line access The care plan, initiated [DATE], did not include focus, goals or interventions related to the central line access. Review of the Medication and Treatment Administration Records (MAR/TAR) for February 2025 showed no routine dressing changes or flushes were documented. Review of a progress note, dated [DATE] at 4:04 PM, showed Staff C, RN, Resident Care Manager (RCM) performed a dressing change to the PICC line (peripherally inserted central catheter) to the right upper chest. Review of the [DATE] MAR/TAR showed no routine dressing changes were documented. Review of a progress note, dated [DATE] at 4:51 AM, showed Resident 1's son alerted staff they were concerned regarding the resident's change in mentation. The resident was confused and unable to follow directions. The facility LN attempted to give oral medication, but the resident was unable to swallow. Resident 4's son called 911. The EMT's arrived around 9:30 PM and noted the resident had elevated temperature and blood glucose. The resident was transported to the hospital. Review of the Hospital admission record, dated [DATE], showed Resident 1 was admitted for bacteremia (bacterial infection in the blood stream). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A surgical consult report, dated [DATE] at 10:15 AM, showed surgical consult was sought for Central Line removal due to suspect sepsis from possible line infection. Family was consulted regarding risks and benefits and the decision to place the resident on comfort measure was made. Review of the Hospital Discharge Summary. dated [DATE]. showed Resident 1 expired at 1:38 PM. On [DATE] at 2:30 PM, Staff D, Licensed Practical Nurse, said they know how often to flush, change needless valve, and change dressing and tubing for IVs by the order on the MAR. Staff D said they would not change the dressing as that was done by the RN (Registered Nurse). Staff D said if a central line was not being accessed (no current medication orders) she would expect it to be flushed and dressed. Staff D said they would know the frequency by the order. Staff D said residents with IV access were at risk for infection if not dressed and flushed appropriately. Staff D recalled Resident 1 but did not recall any treatment regarding the central line. At 3:14 PM, Staff C said that IV batch orders were entered on admission and dressings should be changed seven days. Staff C said a deaccessed central port would still be flushed every shift and dressing changed weekly. Staff C said she recalled Resident 1 had a central line and it was not accessed. Staff C said if a line was not flushed, and a dressing was not changed that could increase the risk of infection for the resident. Staff C reviewed order for Resident 1 and said the orders for maintenance should have been there. Staff C said if the line was not to be accessed or flushed or required a dressing, she would expect there to be an order and that to be included on the careplan. At 3:58 PM, Staff B, RN, Director of Nursing, said orders for IV maintenance would be added on admission and entered into the careplan by the RCM who was doing the resident admission. Staff B said IV-line dressing should be changed weekly and flushed twice daily. She would expect deaccessed lines to be maintained per provider or pharmacy recommendations. Resident 2 was admitted to the facility on [DATE]. The admission MDS, dated [DATE], showed Resident 2 was cognitively intact, medically complex and had a feeding tube (a thin, flexible tube inserted through the skin and into the stomach. It is used to provide nutrition and medication when a person is unable to eat or drink normally) on admission. The care plan focus for tube feedings was added on [DATE], 11 days after admission, and included the goal that the resident would remain free of complications of tube feeding and included interventions to monitor, document, and report to nurse/MD aspiration/fever, or shortness of breath, but did not include the intervention to keep the head of the bed elevated to decrease risk of aspiration. Review of the progress note, dated [DATE] at 2:02 PM, showed Resident 2 had two episodes of emesis, the resident was given medication to control the emesis and the tube feeding was turned off. Review of resident progress notes showed no skilled nursing assessment note for [DATE]. Review of the progress note, dated [DATE] at 2:01 PM, showed Resident 2 was administered 2 liters of oxygen due to Low sats. Review of the progress note, dated [DATE] at 6:48 AM, showed Resident 2's oxygen saturation was , d+[DATE]% on 3 liters of oxygen, they were lethargic and had a change in mentation, resident requested to go to the hospital. 911 was called and resident was transported to the hospital. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 2's vital signs record showed no documented body temperature, oxygen levels, heart rate or respirations from [DATE] through [DATE] following the episodes of emesis, placing the resident at increased risk of aspiration pneumonia. Review of Resident 2's hospital admission record dated, showed the resident was admitted to the hospital for acute (sudden) respiratory failure hypoxia (low blood oxygen) and expired on [DATE] at 3:58 PM. On [DATE] 12:09 PM, Resident 2's Family Member (FM) 2 said they visited the resident about three times a week and frequently reported care concerns to the staff. They found out the resident was vomiting after observing dried vomit on the resident, gown and sheets, they attributed it to the pain medications they were on, and it was supposed to be discontinued but that did not happen. FM 2 said the resident continued to vomit and ended up being admitted to the hospital and died . On [DATE] at 10:25 AM, Resident 2's FM 1 said they visited Resident 2 daily and the resident reported they had been vomiting. They had a care meeting, and they reported the concern about her vomiting and were worried about her aspirating. FM 1 said they observed instances where the head of the bed was flat, and she would have to raise it when she got there and another time when there was visible dried vomit on the sheets, and she reported it to staff but it was still there when FM2 came to visit. On [DATE] at 2:33 PM, Staff E, Nursing Assistant (NA), said they would report changes such as emesis to the nurse and if a resident was receiving tube feeding it would be important to keep the head of the bed elevated to 45 degrees to ensure the resident does not aspirate. Staff E said the beds were not marked where 45 degrees was. On [DATE] at 2:06 PM, Staff F, NA said they would report episodes of emesis to the nurse and residents receiving tube feeding would need to have the head of the bed elevated to 35 degrees. Staff F said the beds were not marked but she could tell where the appropriate level would be. Staff F said they did recall Resident 2 having episodes of emesis and reported to the LN and made sure the head of bed was elevated. At 2:30 PM, Staff D, Licensed Practical Nurse, said if a resident who was receiving tube feeding had emesis, she would stop the feeding and notify the provider and monitor for fever and abnormal lung sounds and oxygen levels. Staff D said she did not recall seeing Resident 2's head of the bed flat but did recall there were nursing students, and she had to give them reminders to keep the head of the bed above 30 degrees. At 3:14 PM, Staff C, Registered Nurse (RN), Resident Care Manager, said a resident who required tube feeding would have interventions care planned to monitor for aspiration and keep the head of the bed elevated. If the resident had an episode of emesis, they would monitor for aspiration by obtaining vital signs and listening to their lung sounds. This would be documented in the progress notes and the vital signs would be under the vitals tab in the resident's record. Regarding Resident 2 she would expect frequent oxygen levels to have been checked and documented. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 3:38 PM, Staff B, RN, Director of Nursing, said a resident receiving tube feeding should have careplanned interventions that included to keep the head of the bed elevated to prevent aspiration. Staff B would expect staff to document their assessment of the resident and monitoring of pulse, temp and oxygen level in the resident record. Reference WAC [DATE] (1)

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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** 45203 Based on observations and interview, the facility failed to ensure the resident audible call system was functioning properly and repaired timely for 2 of 4 resident halls reviewed for call light systems. This failure placed residents at risk for delayed staff response to potential emergencies and resident needs, falls, injury and decreased quality of life. An intake reported on 03/04/2025 at 3:32 PM, documented the facility's audible call light system was not working for rooms 1-17 and manual bells were provided for the residents. On 03/07/2025 at 11:35 AM, the call light to room [ROOM NUMBER] was observed and it was noted there was no audible alarm. At 4:15 PM, Staff A, Administrator, said the repair company had been there, and they had to order a part, it had not arrived yet. They had passed out bells to the residents effected. On 03/19/2025 at 11:30 AM, Staff A said the part to repair the audible portion of the call light system had not arrived. At 11:50 AM, call light to room [ROOM NUMBER] was observed on, there was no audible alarm. At 11:51 AM, the call light for room [ROOM NUMBER] was on, the resident could be heard yelling for help. The resident was seated in their wheelchair, no manual bell was within reach. At 2:30 PM, Resident 3 was observed sitting in his wheelchair, call light not within reach, attached to the opposite side of the bed, a manual bell sat on the sink, Resident 3 said he had no idea what the bell was for. On 04/02/2025 at 11:25 AM, call light to room [ROOM NUMBER] was observed on, no audible alarm. At 11:40 AM, Staff A said the part came in but was not sure of the status of the repair. When asked if facility maintenance staff were repairing it or if an outside company was coming to repair, she replied, a little of both. At 1:03 PM, Resident 4 did not have a manual call bell. Staff present handed them their roommate's bell. On 04/03/2025 at 4:37 PM, Staff A said the audible part has been replaced/repaired but it was very light/quiet and they had a call out to the repair company to adjust the volume. At 4:44 PM, the audible alarm was tested for rooms 1-17 and no audible alarm was heard. Reference WAC 388-97-2280 (1)(a)