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	04/08/2025

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45203 Based on interview and record review, the facility failed to ensure discharge planning included assessment of resident's ability to manage medications, prepare or have access to prepared meals, and to handicap accessible living quarters for 1 of 3 residents (Resident 1) reviewed for discharge planning. This failure placed residents at risk for unmet care needs, psychological distress, re-hospitalization , and a decreased quality of life. Findings included . Review of the facility policy titled, Resident Discharge, revised 05/18/2023 showed that discharges must follow all state requirements to ensure safe and proper discharge for residents and it should include in the plan for the resident's continuity of care and reduction of potential transfer trauma. Resident 1 was admitted to the facility on [DATE]. The annual Minimum Data Set (MDS), and assessment tool, dated 02/28/2025, showed Resident 1 was cognitively intact, required the use of a wheelchair, required daily medication via injections, and that discharge planning was occurring for the residents. The care plan focus for discharge plan, initiated 07/11/2024, showed Resident 1's discharge plan was to remain in the facility. The focus included the information that the resident was given a 30-day eviction notice, but no discharge placement was available and they would remain in the facility until placement was found. Review of the nursing home transfer or discharge notice, dated 02/10/2025, with effective date of discharge of 03/10/2025, showed the resident was being discharged due to no longer requiring skilled nursing services and he exhibited behaviors that threatened the safety of others around him. (continued on next page)

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

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/20/2025 at 5:18 PM, Resident 1's family member (FM) said Resident 1 had appealed the discharge from the facility and the hearing was postponed until 04/03/2025 so he could get legal representation for Resident 1. He understood Resident 1 had behaviors and was trying to work with CC1 (State Agency case worker) to find community placement. It was his understanding that Resident 1 would be able to remain in the facility until the rescheduled appeal hearing. Resident 1's FM said then on 03/13/2025 he received a call that the resident was being discharged to a local hotel. FM said when he arrived the resident was not able to navigate the two stairs to enter the room, the rooms were not wheelchair accessible and there were no safety bars in the bathroom. FM said medications were sent with Resident 1, but he doubted Resident 1's ability to be able to manage and self-administer them. Resident 1's FM said he called 911 shortly after arrival to the hotel due to concern Resident 1 was having a low blood sugar issue. Review of the Inpatient Admission History and Physical, dated 03/13/2025, showed Resident 1 was admitted to the hospital on 03/13/2025. On 03/21/2025, CC2, hotel staff, said the reservation for Resident 1 was not for a handicapped accessible room and they did not offer that, they did not have ramps or grab bars in the rooms stating, the rooms are very minimal, if they needed that, this may not be the best place for them to go. At 2:02 PM, CC1 said they were trying to find placement for Resident 1, but it was challenging due to his behavior. CC1 said they were aware Resident 1 was given a 30-day notice to discharge but was under the impression it was on hold due to the appeal. CC1 said they were not told the resident was discharged to a local hotel until after the fact. CC1 did not feel that was a safe or sustainable discharge. On 3/25/2025 at 11:48 M, Resident 1 said he was still in the hospital, and said he didn't remember much about the discharge other than he appealed to the discharged and thought he would be able to stay at the facility until the hearing. Resident 1 said the facility staff brought all of their medications and insulin (medication used to manage blood glucose levels and required injection by syringe). Resident 1 said he did not recall the facility offered him the opportunity to draw up his own insulin or self-manage his meds prior to the discharge. Resident 1 said he had no idea what he was supposed to do about meals. On 4/08/2025 at 2:08 PM, Staff C, Licensed Practical Nurse, Resident Care Manager, said she made sure residents were sent home with their medications, most had someone at home to help them. When asked about residents discharging home independently, did the facility assess if they could manage medications and self-administer insulin, Staff C said, No, they don't do that . They make sure the residents know what mediations they take and when they are due. Staff C said Resident 1 was discharged like any normal resident with his meds and a copy of the medication list and said, he knew all about his medications. Staff C was not aware of a self-medication evaluation having been done. Review of Resident 1's Electronic Health Record did not show any documented evaluation/assessment done to determine Resident 1's ability to independently manage his oral medications and/or his insulin. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 2:40 PM, Staff B, Registered Nurse, Director of Nursing, said if a resident was discharging independently, they would evaluate the resident to determine if they could safely manage their medications, this was usually done by return demonstration and documented in the record under progress notes or evaluations. Regarding Resident 1, Staff B said they went over the medications with him may times, He knew what medications he was on and was able to check his blood glucose. Staff B said therapy evaluated the resident for safe ambulation to and from the bathroom, could stand and do steps, and that they tried to make it a smooth transition. and that leading up to the moment of discharge the facility had been trying to check as many things as they could off the list. Staff B said she felt Resident 1 could take care of some of the things himself. Staff B said she would expect a safe discharge to include a self-medication management assessment, handicapped accessible living space and access to or the ability to prepare meals. Documentation regarding physical therapy assessment and medication management evaluation after the 02/10/2025 discharge notice was requested. On 04/08/2025 at 3:04 PM, Staff A, Administrator, said she made the reservation for the hotel room for Resident and had offered to pay for the first week. She did not know if it was handicapped accessible or not. Staff A was not aware if a self-medication management assessment had been completed for Resident 1 but said he was able to manage his medications, if he wanted to. Staff A said she did not know if the resident had the ability to prepare meals or if his room was equipped to allow meals to be prepared and said Resident 1 had funds and could purchase food. Staff A believed Resident 1's discharge was safe for him stating he could do a lot on his own. No documentation regarding physical therapy assessment and medication management evaluation after the discharge notice was given was provided to complaint investigator. Reference WAC 388-97-0080