

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505185	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2025
NAME OF PROVIDER OR SUPPLIER Olympic View Care		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45203</p> <p>Based on interview and record review the facility failed to initiate a resident grievance for 2 of 5 sampled resident (Resident 1 and 2) reviewed for grievances. This failure placed the residents at risk of not receiving a grievance resolution, a denial of personal rights and a diminished quality of life.</p> <p>Findings included .</p> <p>The Facility Policy titled, Grievances, revised 02/2024, documented that the grievance process was for both residents and resident representatives, included a process for receiving, tracking and concluding for any and all concerns. Grievances were to be logged on the Grievance Log, and the resident or resident representative should receive communication within 5 days for resolution.</p> <p><Resident 1></p> <p>Resident 1 was admitted to the facility on [DATE]. The admission MDS (minimum data set), an assessment tool, date 03/25/2025, documented Resident 1 was cognitively intact, and required substantial to maximal assistance of staff for completion of activities of daily living (ADL's). The care plan initiated on 03/18/2025 included only one Focus: ADL deficit related to COPD (chronic obstructive pulmonary disease) and included the intervention to monitor, document, and report any changes to the nurse.</p> <p>Review of Resident's progress notes from 03/18/2025 to 03/29/2025 showed no daily skilled clinical note entered for 03/21/2025 through 03/27/2025.</p> <p>A progress note, dated 03/28/3035 at 7:11am, showed Resident 1 had an episode of emesis (vomiting) during the night and the nurse notified the provider by written form and requested an antiemetic (anti-nausea medication)</p> <p>A progress note, dated 03/29/2025 at 1:15pm, showed the resident was lethargic, with low blood pressure, increased pulse and increased body temperature and the family strongly insisted the resident be transported to the emergency room .</p> <p>A hospital admission history and physical, dated 03/29/2025, showed Resident 1 was admitted to the hospital for septic shock secondary to pneumonia.</p> <p>(continued on next page)</p>

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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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility's grievance logs for March 24,2025 through April 23, 2025, did not show an entry related to Resident 1.</p> <p>On 04/22/2025 at 4:07pm, Resident 1's FM (family member) said they went to visit Resident 1 on 03/29/2025 and found the resident was not responsive. They were unable to locate nursing staff and approached staff located in the lobby, the receptionist, identified as Staff D. FM reported their concern to Staff D and reportedly the staff member raised their voice and yelled at the FM telling them, She is just sleeping, that is what people with Alzheimer's do, the nurses took her vitals, and she is fine, don't you think we know when to send someone to the hospital? FM reported that Staff D followed her back to Resident 1's room and kept talking over her. Resident 1's FM reported they left the facility and overheard Staff D taking to someone on speaker phone regarding Resident 1. Approximately 10 minutes later, after Resident 1's FM arrived home, Staff E called them and reported that Resident 1 was noted to be lethargic and offered to call 911. FM said they were called by the EMTS approximately 10 minutes later and it was reported Resident 1 had a body temperature of 102 degrees and they were administering intravenous fluids. FM said they tried to file a grievance on 3/31/2025 but there did not seem to be a formal process. FM reported they spoke to, the head nurse, about how staff treated them and concerns for lack of care. And they were told they would pass it on to the administrator. FM reported they called the facility on 04/04/2025 to follow up and Staff A told them Staff D no longer worked there and would not provide any additional details.</p> <p>On 04/25/2025 at 1:29pm, Staff B, Registered Nurse (RN), Director of Nursing (DNS), said if a resident's family member reported a care concern, they would review it to determine if it was grievance versus abuse or neglect. They would investigate to determine the resolution process and address the concerns. Staff B did not recall having a conversation with Resident 1's FM. Staff B said they were called on 3/29/2025 by Staff E and was aware of, an incident that weekend and Staff E was sending Resident 1 to the hospital. Staff B said they heard from Staff A that FM 1 reported that Staff D was rude to them, and Staff A was going to follow up after speaking to Staff D. Staff B said she would expect that an offer of formal grievance would have been extended, and they would have expected it to be on the grievance log.</p> <p>At 1:52pm, Staff A, Administrator, said she received most calls related to care concerns and she looked into them and gave them an answer and determined if there was something they needed to do differently to solve the issue. If it had to do with a resident decline, she would refer to Staff B. Staff A recalled talking to Resident 1's FM more than once and was working it out. Staff A did not consider staff being rude to a family member expressing concerns over resident decline, a grievance. Staff A said the family was concerned that staff were not monitoring the resident, but they were. Staff A said they did interview staff and Staff D was terminated, for other reasons. Staff A said they did not have any documentation regarding these situations and said they probably should have put it on the grievance log.</p> <p><Resident 2></p> <p>Resident 2 was admitted to the facility on [DATE]. The Admission MDS, dated [DATE], showed Resident 2 was cognitively intact, medically complex, and required substantial to maximum assistance from staff for ADL's.</p> <p>Review of the facility's grievance log for February 2025 did not show an entry for Resident 2.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 04/25/2025 at 12:36pm, Resident 2 said they were not familiar with the facility's grievance process but had lost a pair of reading glasses shortly after admission, he reported that to a Nursing assistant. The glasses were never replaced so he had to buy another pair.</p> <p>At 1:21pm Staff C, Nursing Assistant, said if a resident reported missing items, they would first look for the item, for example in laundry, then get a grievance form and help the resident fill it out and turn it in to Staff A.</p> <p>At 1:29 Staff B, RN, DNS, said missing items were sometimes placed on a grievance form, and there was also a list in the social service office.</p> <p>At 1:52pm Staff A, Administrator, said that there was not a form to fill out for a missing item, when a missing item was reported they attempted to find it and if it was not found they would offer to replace it. Staff A said they kept a log of missing items. When asked about Resident 2's missing glasses, Staff A said the missing reading glasses were not logged on her list of missing items for February 2025. Staff A said she recalled hearing about them, she was going to replace them and assumed that didn't happen.</p> <p>Reference WAC 388-97-0460</p>		