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	08/01/2025

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** .Based on interview and record review, the facility failed to report and investigate an incident of potential neglect for 1 of 1 resident (Resident 1) reviewed for hospitalization related to a preventable complication of a suprapubic catheter. This failure limited the opportunity for the facility to identify and correct system failures that contributed to the residents' decline.Findings included.Resident 1 admitted to the facility on [DATE] with a diagnosis of Obstructive Uropathy (a urinary tract disorder that occurs when the urine flow is blocked) and had an indwelling urethral (the tube that carries urine from the bladder out of the body) catheter (a tube inserted into the bladder to drain urine). The quarterly Minimum Data Set (MDS, an assessment tool) showed Resident 1 was cognitively intact and needed minimal assistance with activities of daily living (ADL's). On 07/25/2024, the urethral catheter was replaced with a suprapubic (small hole in the lower abdomen leading to the bladder) catheter. Resident 1 was admitted to the hospital on [DATE] due to an obstructed (blocked) suprapubic catheter. Review of the hospital documentation showed calcifications (build up of calcium salts that harden) had grown around the insertion site in the bladder. The balloon (fluid filled end of the catheter that holds it inside of the bladder) of the catheter was hardened and difficult to remove. Resident 1 had to undergo surgical and intravenous (in the vein) medication interventions for removal of the catheter and for cellulitis (skin infection), caused by leaking urine, to the groin area and down both legs. Review of facility records showed the catheter had not been changed since 11/12/2024. Review of clinical orders, dated 08/28/2024, showed the catheter should have been changed monthly. On 07/07/2025 at 2:35PM, Staff B, Director of Nursing (DNS) was asked about the investigation into the hospitalization for Resident 1. They said they had not completed one. When asked if they were aware the hospital had requested documentation regarding the last time the suprapubic catheter had been changed, they said they were not. On 07/29/2025 at 1043 AM, Staff D, Admissions Coordinator, said they had called and emailed Staff B on 06/24/2025 about receiving the records request from the hospital. Staff D said they were told by Staff B that the catheter was being changed by an outside clinic and did not have the records. On 07/29/2025 at 4:50PM, Staff B, DNS was asked if they had been contacted by Staff D, Admissions Coordinator on 06/24/2025 about the request for the records. Staff B said they didn't remember. On 07/29/2025 at 5:00PM, Staff A, Administrator, said the catheter complication and subsequent hospitalization should have been investigated. They said the incident should have been reported to the appropriate agencies. Reference WAC 388-97-1640(5)(a)

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	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Olympic View Care	1116 E Lauridsen Boulevard Port Angeles, WA 98362

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)

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	505185	A. Building B. Wing	08/01/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on observation, interview, and record review, the facility failed to provide the appropriate care and services for 2 of 3 residents (Resident 1 and Resident 2) reviewed for indwelling catheter (a flexible tube inserted into the bladder to drain urine) care and maintenance. Resident 1 experienced harm when their indwelling suprapubic urinary catheter was not changed monthly as ordered and required hospitalization due to catheter related complications. This failure placed residents with indwelling catheters at risk of medical complications. Findings included.An Indwelling Catheter Policy, revised 12/2024, stated indwelling catheters need, Orders to include type of catheter (size and balloon size), diagnosis, and catheter change orders to include change complete catheter system prn, blockage, leakage, encrustation, catheter care every shift and change catheter bag as needed.<Resident 1>Resident 1 admitted to the facility on [DATE] with a diagnosis of obstructive uropathy (a urinary tract disorder that occurs when the urine flow is blocked) and had an indwelling urethral catheter. The quarterly Minimum Data Set (MDS, an assessment tool) showed Resident 1 was cognitively intact and needed minimal assistance with activities of daily living (ADL's). Review of the electronic medical record (EMR) showed Resident 1 had the indwelling urethral catheter removed and a suprapubic (small opening in the lower abdomen through which a catheter is inserted directly into the bladder) catheter placed on 07/25/2024. Orders documented to follow up in four to six weeks for catheter change. Resident 1 was seen at a clinic on 08/24/2025 where the suprapubic catheter was changed and was sent with orders following that visit said to change out the catheter monthly. Review of the care plan, dated 07/26/2024, showed to document the size and type of catheter to change the catheter per physician order. Review of the Treatment Administration Record (TAR) from July of 2024 to June of 2025 did not have an order to change the catheter.Review of the EMR showed the suprapubic catheter was changed out by the facility Physician Assistant-Certified (PA-C) on 10/02/2024 and 11/12/2024. Review of a Resident Choice of Medication, Treatment and/or Dietary Restriction form, dated 11/12/2024, was signed by the PA-C and Resident 1. The form addressed the following risks of not changing the catheter out monthly: urinary tract infection, catheter blockage, bladder spasms, skin breakdown, bladder stones, and/or kidney failure. o Review of progress notes, dated 12/19/2024, 02/01/2025, and 03/10/2025, showed Resident 1 refused the catheter change. No further documentation was provided regarding possible alternatives or the increase in risks. There was no documentation about catheter changes or refusals for January 2024, April 2024, May 2024, or June of 2024. Facility records showed the catheter had not been changed since 11/12/2024 through 06/24/2025 (224 days) when the resident was sent to the hospital. Review of progress notes showed Resident 1 was sent to the hospital on [DATE] due to not having urine output in the collection bag attached to the suprapubic catheter. Review of hospital documentation, showed Resident 1 had significant cellulitis (infection of the skin) along the inside of both legs and groin area from leaking urine. The emergency department attempted to remove the suprapubic catheter, but it was too painful due to calcifications (buildup of calcium salts which harden) that were formed inside the bladder. Resident 1 was admitted to the hospital for surgical removal of the suprapubic catheter and intravenous (in the vein) medications for cellulitis and a urinary tract infection. On 07/29/2025 at 3:40PM, Staff C, Registered Nurse (RN), said they were aware of Resident 1's skin issues but didn't realize how bad they were until the wound nurse notified them on 05/16/2025 and they went to assess. Staff C said there was a strong urine odor. Resident 1 was sent to the hospital and was diagnosed with dermatitis (skin inflammation), was prescribed cream, and was sent back the same day. Staff C said they thought the dermatitis was caused by Resident 1 emptying his urine bag and having some dribble down the legs. When asked if the nursing team had discussed the catheter being changed out, Staff C said they did not. When asked if the skin conditions could have been caused by the catheter becoming obstructed and leaking, they said yes. Staff C said they thought the PA-C was changing it. When asked if changing a suprapubic catheter was within the scope of an RN, they said yes. On 07/29/2025 at 4:25PM, Staff B, Director of Nursing (DNS), said they were not aware that the catheter had not been replaced for several months. Staff B said they thought the PA-C was completing that task. When asked if the facility had a policy for suprapubic catheters, Staff B said they did not. When asked if changing a suprapubic catheter was within the scope of an RN, they responded, yes. On 07/29/2025 at 5:06PM, Resident 1 had returned from the clinic after having their catheter changed. Resident 1 said they had been under the impression that the catheter needed to be changed every 6 months or so. When asked if they had