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	08/12/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on observation, interview and record review, the facility failed to ensure the resident or resident representatives' right to make healthcare choices was upheld. Specifically, the facility did not provide the resident's representative with adequate information or involvement in decision making related to care and treatment for 1 of 3 residents (Resident 1). This failure placed residents and their representatives at risk of not being able to make informed decision regarding care and services.Findings included.A Resident Rights Policy, undated, given to all residents and or resident's representatives on admit, stated, You have the right to be informed of, and participate in, your treatment, including the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option you prefer.Resident 1 admitted to the facility on [DATE] and had a history of skin cancer. The quarterly MDS, dated [DATE], showed Resident 1 had severe cognitive impairment and was dependent on staff for all activities of daily living. Review of the Treatment Administration Record for July 2025 showed Resident 1 was receiving wound care for a cancerous lesion to their forehead, two times a day. Review of a wound care progress note, dated 07/28/2025, documented the wound had excessive drainage and was very painful for the resident. During interview on 08/01/2025 at 10:45 AM, Staff C, Licensed Practical Nurse (LPN) said they were called into Resident 1's room around 5:00 AM on 07/30/2025 as maggots had been discovered in the wound. Staff C said they reported it to the oncoming nurses but did not notify the family.Review of a progress note, dated 07/31/2025 at 8:21 AM, showed moving organisms were present in the wound during a dressing change. The note showed a supervisor and a charge nurse were notified but did not make note that family was notified.Review of a Social Services progress note, dated 07/31/2025 at 9:28 AM, showed the facility provider had spoken with the family in regard to moving Resident 1 to a private room but did not mention any discussion about the maggot infestation. During interview on 08/01/2025 at 1:15 PM, Staff D, Physician Assistant -Certified, Travel Agency, said they provided the best treatment they could for the infestation. When asked why Resident 1 was not sent to the hospital, Staff D said they were told by facility staff that the family did not want hospitalization. When asked if they had spoken to the family, Staff D stated, No, because I thought [Staff B, Director of Nursing (DNS)] had.On 08/01/2025 at 3:12 PM, Staff B, DNS, said they did not notify the family. When asked if the family should have been notified so that they could have made an informed decision about treatment including possible hospitalization, Staff B stated, Yes, everyone has that right, but I thought the nurse that found the maggots talked to them.Reference WAC 388-97-0300(3)(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	08/12/2025

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on observation and interview, the facility failed to provide a safe and sanitary environment for residents and staff related to shower rooms, utility rooms, and equipment storage rooms. This failure placed residents and staff at risk for injury, cross contamination (process by which bacteria or other microorganisms are transferred from one subject or object to another), and a decreased quality of life. Findings included.During an observation on 08/12/2025 at 1:15 PM, the shower room on the [NAME] wing was observed. The floor was littered with garbage (used gloves, paper towels, wipes). There were several personal hygiene items (body wash, shampoo, lotions) open and scattered around the room. The toilet had a brown ring inside of it with a piece of toilet paper hanging down. The drain for the shower was not covered. The exhaust fan in the ceiling was not covered and had wires hanging down.During an observation on 08/12/2025 at 1:30 PM, resident room [ROOM NUMBER] was observed. The door was open. There were several pieces of equipment being stored (beds, wheelchairs, air mattresses, mechanical lift devices). An air mattress was observed on the floor where dirt and dead insects were seen. Two garbage containers were noted by the door with lids ajar. Inside were bags of used incontinence products. There was a laundry container that had bags of dirty clothes. During an observation on 08/12/2025 at 1:40 PM, the soiled utility room on the East wing was observed. There was garbage on the floor (oxygen masks and gloves). Isolation carts filled with clean gloves, gowns, and masks were observed. The hopper (a type of sink used for waste disposal, such as feces) was empty of water with dark brown rings on the inside.During an observation on 08/12/2025 at 1:50 PM, the shower room on the North wing was observed. There was an uncovered outlet with visible wires. During an interview on 08/12/2025 at 2:00 PM, Staff E, Housekeeping Supervisor, said the garbage and soiled linen containers should not be in room [ROOM NUMBER]. Staff E said the bins should be in a soiled utility room, but the nursing aides moved them out of the shower room due to not having enough space. When asked if the equipment in room [ROOM NUMBER] was clean or dirty, Staff E said they didn't know. During an interview on 08/12/2025 at 2:10 PM, Staff A, Administrator, observed the [NAME] and North shower rooms, the dirty utility room on the East wing, and room [ROOM NUMBER]. They said these rooms were not in safe or sanitary conditions. Staff A said garbage and soiled linen containers should be stored in a dirty utility room. They said isolation carts with clean supplies should not be stored in the dirty utility room. Refer to F552Reference WAC 388-97-3220(1).