

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 09/17/2025
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)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. (continued on next page)

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: 505185	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/17/2025
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 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to involve the resident's representative in the development of the resident's plan of care, inform the representative of changes in the plan of care and review the plan of care for 1 of 3 (Resident 1) residents reviewed. This failure placed residents at risk of lack of advocacy for their healthcare needs, preferences and medical history. Findings included. Resident 1 was admitted to the facility on [DATE] with diagnoses of dementia, bipolar disorder (a chronic mental health condition characterized by extreme mood swings) and diabetes (a condition where the body does not produce or use insulin effectively, leading to high blood sugar levels). Resident 1's Clinical admission Assessment, dated 08/05/2025, showed Resident 1 was chronically confused and had moderate cognitive impairment. Resident 1's Durable Power of Attorney for Health Care (DPOA-HC) dated 10/02/2023 and uploaded to Resident 1's electronic medical record (EMR) on 08/05/2025, showed Collateral Contact 1 (CC1) was Resident 1's chosen agent and was effective on the date the DPOA-HC was signed. On 09/09/2025 at 1:10 PM, CC1, said Resident 1 had been a diabetic for years and had been on insulin to manage their diabetes. CC1 said when Resident 1 was admitted to the facility Resident 1 had not been admitted with insulin orders but CC1 was not informed of that. CC1 said the facility discontinued many of Resident 1's medications for their bipolar disorder that had kept their condition stable without notifying CC1. CC1 said staff informed them the medications were discontinued due to Resident 1 having nausea and vomiting. CC1 said they had not been informed that any medications had been discontinued and were very concerned because CC1's diabetes and bipolar disorder had been stabilized with those medications. CC1 said they were working with an assisted living facility for Resident 1 to move to after their stay at the facility. CC1 said the assisted living facility could not accept Resident 1 due to unstable blood sugar levels. CC1 said they had never seen Resident 1's care plan and had requested to view it, a list of Resident 1's medications, including when medications had been started and stopped and the blood sugar readings. CC1 said they were not contacted until the end of August by the medical provider but had still not received the plan of care and/or the answers to the specific questions regarding the medications even after repeated requests. CC1 said the staff had not made an effort to collaborate with CC1 regarding the plan of care. Resident 1's progress notes, dated 08/06/2025, showed Resident 1 continued with nausea and vomiting, up throughout the night with emesis (vomit) brown liquid and the medical provider notified. Resident 1's progress note, dated 08/07/2025, showed an IV (a catheter used to administer medications and/or liquids into a vein) was inserted and Sodium Chloride (solution used to rehydrate) was running per the orders. Resident 1's medical provider notes, dated 08/07/2025, showed Resident 1's dementia was advanced, and they were oriented to self and place but had marked short term memory loss. The note showed since arrival at the facility, Resident 1 had nausea and vomiting, somnolence (sleepiness), and poor intake. The note showed the nausea, vomiting, and somnolence was possible due to medication or metabolic cause and the plan was to order labs and start IV fluids for 48 hours for hydration. The noted showed staff were to discontinue medications to include medications for diabetes and bipolar disorder. Resident 1's EMR (electronic medical record) showed no notification to CC 1 regarding the medications being discontinued, lab orders and/or the IV hydration. Resident 1's medical provider notes, dated 08-29-2025, showed a care conference was held with the resident and CC1. The note showed the staff discussed multiple issues regarding Resident 1's admission, medication management and progress. On 09/17/2025 at 1:12 PM, CC2, resident advocate, said they had attended Resident 1's care conference on 08/29/2025 and the facility staff were unable to answer all CC1's questions. CC2 said it was very frustrating. Review of an email from CC1 to facility staff, dated 09/04/2025, showed CC1 addressed concerns to the team that was taking care of Resident 1 to include: the plan for Resident 1 due to their insurance ending, an assessment of Resident 1's current condition, Resident 1's medication list, a final report from PT [physical therapy], OT [occupational therapy] and ST [speech therapy]. The email showed that CC1 did not know Resident 1's plan of care and it was not discussed in the care meeting. Review of an email from facility staff, dated 09/04/2025, showed facility staff responded to CC1's questions but wrote that CC1 should let them know if they still had concerns. Review of an email from CC1 to facility staff, dated 09/05/2025, showed CC1 had questions that were not addressed in the 09/04/2025 email from facility staff and had asked for a care plan and had not received it. CC1 wrote it was a deep concern to them. CC1 requested information about a swallowing issue from the evening prior. Facility staff responded to</p>		

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 09/17/2025
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 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, quality laboratory services/tests to meet the needs of residents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to obtain and monitor laboratory tests timely per physician orders for 1 of 3 residents (Resident 1) reviewed. This failure placed residents at risk of clinical complications, unstable medical conditions and delayed recovery. Findings included. Resident 1 was admitted to the facility on [DATE] with diagnoses of dementia, bipolar disorder (a chronic mental health condition characterized by extreme mood swings) and diabetes (a condition where the body does not produce or use insulin effectively, leading to high blood sugar levels). Resident 1's medical provider notes, dated 08/07/2025, showed since arrival at the facility, Resident 1 had nausea and vomiting, somnolence (sleepiness), and poor intake. The note showed the nausea, vomiting, and somnolence was possible due to medication or metabolic cause and the plan was to order labs and start IV fluids (liquids administered through a catheter in the vein) for 48 hours for hydration. The note showed the plan was to order laboratory tests. Resident 1's physician orders, dated 08/07/2025, showed an order to draw a CMP (test to monitor electrolyte balance), CBC (blood test that measures the number and types of cells in the blood), TSH (blood test to monitor thyroid function), Hgb A1C (lab related to diabetes) and a valproic acid level (anti-seizure medication - checking for level of medication in blood). Resident 1's provider notes, dated 08/19/2025, showed labs still pending and Depakote was held pending labs. Review of Resident 1's laboratory results, dated 08/25/2025, showed results for CMP, CBC, and TSH. Review of Resident 1's laboratory results, dated 09/04/2025, showed results for a valproic level. Review of Resident 1's electronic medical record (EMR) showed no result for the Hgb A1C. On 09/17/2025 at 2:33 PM, Staff A, Resident Care Manager and Licensed Practical Nurse, reviewed Resident 1's EMAR and contacted the facility laboratory to obtain all lab results from Resident 1. Staff A could not locate a Hgb A1C lab result and verified the CMP, CBC and TSH were not collected until 08/25/25 and the valproic acid level was completed on 09/04/2025. On 09/17/2025 at 4:00 PM, Staff B, Director of Nursing, said when medical providers order labs to be drawn they expect them to be completed timely. WAC Reference 388-97-1620(2)(b)(i)</p>		