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	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Olympic View Post Acute	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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the Power of Attorney and or Legal Guardian of significant changes for 1 of 3 residents (Resident 1) reviewed for significant changes. This failure placed responsible parties at risk for not being able to make informed decisions. Findings included.Resident 1 admitted to the facility on [DATE] and had a diagnosis of Dementia. The significant change Minimum Data Set (an assessment tool), dated 09/29/2025, showed Resident 1 was severely cognitively impaired. Review of Resident 1's profile/demographics showed they had a legal guardian in place who was the first contact for any changes.Review of hospital records, dated 10/05/2025, showed Resident 1 was seen in the emergency room due to an assault by a roommate. Resident 1 had suffered skin impairments to the left elbow and left pointer finger lower knuckle. Resident 1 was returned to the facility later that same day and was moved to a different room. On 11/18/2025 at 2:51PM, Collateral Contact 1 (CC1), Legal Guardian, reported they had not been informed of the altercation and subsequent injury, the emergency room visit, or the room change.On 11/25/2025 at 4:15PM, Staff A, Administrator, said staff should have contacted the legal guardian as soon as the incident occurred and informed them of the room change.Reference WAC 388-97-0320(1)(a)(d)(2)(a)(b)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide ordered pain-relieving interventions in a timely manner for 1 of 3 residents (Resident 1) reviewed for pain management. This failure placed residents at risk for unmet needs, anxiety, and a diminished quality of life.Finding included.Resident 1 admitted to the facility on [DATE] at 2PM from the hospital after having a left ureteral stint placement (a procedure where a thin, flexible tube is inserted into the ureter to ensure urine flows from the kidney to the bladder). The admission 5-day Minimum Data Set (an assessment tool), dated 11/12/2025, showed Resident 1 was cognitively intact and had pain that interfered with activities of daily living. During an interview and observation on 11/25/2025 at 2:35 PM, Resident 1 said they had severe pain to the left flank, 7 out of 10 on the pain scale. Resident 1 said they had not received the noon dose of Tylenol and had been waiting for over two hours for as needed (PRN) medication. Resident 1 said they had asked several staff members. Resident 1 said the nurses had not been adequately managing the pain since admission to the facility. Resident 1 stated they did not have any patches on their body. No patches were observed on Resident 1. Review of Resident 1's orders and Medication Administration Record (MAR) for November 2025 reviewed on 11/25/2025 at 2:40PM, showed Resident 1 had the following pain medications ordered and received:Order dated 11/19/2025, tramadol HCl oral tablet every eight hours PRN for groin pain. The most recent dose was documented as given on 11/21/2025 at 6:35PM. Order dated 11/07/2025, lidocaine patches applied topically at 8AM and removed after 12 hours. The most recent application was documented by a medication technician at 8AM on 11/25/2025. Order dated 11/06/2025, oxycodone10 milligrams (m)g every six hours PRN for severe pain. The most recent dose had been documented as given received on 11/25/2025 at 6AM for an undocumented pain level. Order dated 11/06/2025, Tylenol oral tablet 325mg, 3 tablets every 6 hours for pain. The 6AM and 6PM doses were not given on 11/19/2025. The 6AM dose was not given on 11/20/2025 and 11/25/2025. The November 2025 MAR showed Resident 1 did not receive scheduled Tylenol until 12AM on 11/07/2025 and did not receive PRN oxycodone until 8:04AM on 11/08/2025.On 11/25/2025 at 3:30PM, Staff A, Medical Technician, was asked if they were aware Resident 1 was in pain and had requested PRN pain medication. Staff A said they were not aware. When asked if they had applied the Lidocaine patches that morning, Staff A said they had. When informed that Resident 1 did not have any patches on, Staff A said they must have forgotten.On 11/25/2025 at 3:45PM, Staff B, Director of Nursing, said they had completed training with staff about signing for medications before giving them. Staff B did not know why it took 10 hours on the day of admission for Resident 1 to receive Tylenol or why it took 42 hours to receive PRN oxycodone. Staff B said Resident 1 should be receiving scheduled and PRN pain medications in a consistent and timely manner. Reference WAC 388-97-1060(1)