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	01/21/2026

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents received necessary nursing assessment, monitoring, and/or care when licensed nursing staff were not actively involved in the assessment or management of residents' wounds and a change in condition and unlicensed medication or nurse technicians performed wound care and assessments without nursing oversight, resulting in complications and hospitalizations for 2 of 2 residents (Resident 1 and Resident 2) reviewed for care and services. Resident 1 experienced harm when their bilateral lower extremity wounds became infected, the resident had a change in consciousness and required transfer to the hospital where they were diagnosed with severe sepsis with organ disfunction (life-threatening whole-body response to infection). Additionally, the facility failed to ensure orders and care plan were in place regarding a peripherally inserted central line for 1 of 1 resident reviewed for central lines. These failures placed residents at risk for additional delayed treatments, diminished quality of life and medical complications and death.Findings included .RCW 18.88A.082 (4) A medication assistant may not: (a) Accept telephone or verbal orders from a prescriber; (b) Calculate medication dosages; (c) Inject any medications; (d) Perform any sterile task; (e) Administer medications through a tube; (f) Administer any Schedule I, II, or III controlled substance; or (g) Perform any task that requires nursing judgment.Resident 1Resident 1 was re-admitted to the facility on [DATE]. The 5-day admission MDS (Minimum Data Set, an assessment tool), dated 11/11/2025, showed Resident 1 had four bilateral lower extremity venous and or arterial ulcers and was cognitively intact. Resident 1 needed substantial assistance with activities of daily living (ADLs).Review of the December 2025 Treatment Administration Record (TAR) showed lower extremity edema (fluid build-up and swelling, can stretch the skin to the point of blistering and breakdown) monitoring was completed daily. Staff C and Staff D, Medication Technicians, signed off they had assessed and determined the amount of edema present for 13 days of the month (12/01/2025, 12/03/2025, 12/09/2025, 12/10/2025, 12/11/2025, 12/14/2025 -12/17/2025, 12/19/2025, 12/22/2025-12/24/2025).Resident 1's care plan, dated 11/28/2025, did not show documentation of edema or interventions, wounds, wound interventions and treatments, or signs and symptoms of infection. The care plan did not document which staff would be responsible for wound care management.A nursing progress note, dated 12/07/2025, documented bilateral lower extremities had multiple blisters, open wounds, and drainage to the lower extremities. Wound cultures were not ordered until 12/23/2025 when the out of facility wound care team saw the resident.Orders, dated 12/12/2025, showed advanced wound care including cleansing the wounds, application of special sterile dressings (calcium alginate with silver and collagen) was to be provided to the left anterior lower leg, left lateral lower leg, left medial lower leg, and right lateral lower leg in the AM and PM. On 12/14/2025 AM, 12/17/2025 AM, and 12/19/2025 AM, wound care was signed off by Staff C, Medication Technician.A provider note, dated 12/15/2025, documented Resident 1 was somnolent (abnormally drowsy) and was mumbling incoherently. Resident 1 had a (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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	lunch tray in front of him but was not eating. The note speculated that over sedation with oxycodone (a narcotic) was to blame for the drowsiness.Review of the December 2025 Medication Administration Record (MAR) showed Resident 1 had orders for oxycodone HCI, 2.5mg [milligrams] every four hours as needed for moderate to severe pain, and oxycodone HCI, 5mg every four hours as needed for severe pain. Resident 1 received 2.5mg at 4:30AM and 5mg at 11:10AM on 12/15/2025, for a total of two doses. The 5mg dose was discontinued at 2:01PM on 12/15/2025.Review of the Electronic Health Record (EHR) showed no nursing notes from 12/15/2024 through 12/25/2025 when the resident was transferred to the hospital.In an interview on 01/20/2026 at 3:46PM, Staff F, Certified Nursing Aid, said they had been caring for Resident 1 for the night shift, 6:00PM to 6:00AM on 12/24/2025. Staff F said they had been concerned about Resident 1 due to lack of responsiveness. Staff F said they informed the nurse around 9:00PM on 12/24/2025 and again at 4:00AM on 12/25/2025 about their concern. Staff F said the nurse took Resident 1's pulse both times but did not call Emergency Medical Services (EMS). On 12/25/2025 at 6:00AM, Staff G, Licensed Practical Nurse, documented Resident 1 was found unresponsive, with a fixed gaze, and hypothermic (body temperature dropping below 95 degrees Fahrenheit [F]) with a temperature of 90.3 degrees F. Resident 1 was sent to the hospital. Staff G was unreachable for interview.emergency room notes, dated 12/25/2025, documented Resident 1's rectal temperature was between 83-84 degrees F. Cultures from the lower extremity wounds showed gram positive cocci (a type of bacteria), Staphylococcus aureus (a type of bacteria), and Pseudomonas (rod shaped bacteria). Resident 1 also had Staphylococcus epidermidis bacteremia (a blood stream infection). Resident 1 also had thrombocytopenia (low platelets) and the physician documented, severe thrombocytopenia and a positive wound culture for pseudomonas support the diagnosis of sepsis and possible disseminated intravascular coagulation [life threatening condition where blood-clotting mechanisms malfunction]). Resident 1 passed away at the hospital on [DATE].On 01/20/2026 at 4:00 PM, Staff B, Director of Nursing Services (DNS), said assessing for and monitoring of edema was out of the scope of practice for a Medical Technician. Staff B said assessing and treatment of wounds was also out of the scope of practice for a Medical Technician. Staff B said Resident 1 should have been placed on alert charting for the increase in wound drainage, medication changes, and for clinical deterioration. Staff B said Licensed Nurses (LN) should have been performing all wound care for Resident 1 and should have been documenting a detailed recording of the wounds.Resident 2Resident 2 was admitted to the facility on [DATE] with a diagnosis of severe esophageal stenosis (narrowing of the esophagus making it difficult to swallow). The 5-day admission MDS, dated [DATE], showed Resident 2 was moderately cognitively impaired and needed partial assistance with ADLs.Resident 2's care plan, dated 10/27/2025, showed Resident 2 was on a full liquid diet consisting of supplements. Resident 2's liquids could be thin in consistency. A Daily Skilled Evaluation Form, dated 12/17/2025 AM shift, documented Resident 2 had normal breathing patterns, did not have shortness of breath, and had clear lung sounds. No nursing evaluations were completed for 12/18/2025 or 12/19/2025.A provider note, dated 12/18/2025, documented Resident 2 was short of breath, had audible wheezing, and had a non-productive cough. A chest x-ray was ordered but was not completed.A nursing note created by Staff E, Nursing Tech, dated 12/20/2025 at 6:53 PM, documented Resident 2 was struggling to breathe, had audible wheezing, and was coughing up blood. Staff E called EMS. Resident 2 was taken to the hospital and admitted for aspiration pneumonia (lung infection caused by inhaling substances such as liquid).On 12/29/2025 at 5:20 PM, Staff E, Nurse Technician, said Resident 2 had been coughing up blood for two days. When asked if a Registered Nurse (RN) had assessed the resident in the previous two days, they said they did not know. When asked if a Registered Nurse had assessed the resident before EMS was called, Staff E stated, No. When asked (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	why, they said there was only one RN in the building for 83 residents. Staff E said they felt overwhelmed at the time.On 12/29/2025 at 5:30 PM, Staff B, DNS, said due to Resident 2's symptoms, the chest x-ray should have been obtained as soon as possible. Staff B said Resident 2 should have been placed on alert and closely monitored by an LN. Staff B said it was out of Staff E's scope of practice to make the judgment call to send a resident to the emergency room. On 12/29/2025 at 5:45 PM, Staff A, Administrator, said the facility would no longer be employing Nurse Technicians or Medication Technicians. Staff A said LN's should have completed and documented assessments of all residents.Resident 3Resident 3 was admitted to the facility on [DATE] for intravenous (via the vein) antibiotic therapy for pneumonia (lung infection). The 5-day admission MDS, dated [DATE], showed Resident 3 was cognitively intact and needed substantial assistance with ADLs. Resident 3 had a Peripherally Inserted Central Catheter (PICC -thin, flexible tube inserted into an arm vein and guided to a large vein near the heart), in their right arm.A provider note, dated 12/18/2025, documented Resident 3 had concerns about the PICC dressing as it was falling off and was at risk for infection. The note said nursing would be notified so that it could be changed.Review of the December 2025 TAR showed two orders for PICC dressing changes. The first order read to change weekly and was completed on 12/14/2025. The second order read to change as needed every 24 hours. There was no documentation the dressing had been changed on 12/18/2025. Both orders read, Measure upper arm circumference and external catheter length on admission and with each dressing change. There was no documentation providing this information.Resident 3's care plan, dated 12/15/2025, acknowledged the presence of a PICC in the right arm but there were no interventions or what to monitor for. There were no directions on blood draws. There were no instructions about not taking blood pressures on the right arm. There were no instructions on the sterile technique process required for dressing changes.On 12/29/2025 at 4:15PM, Staff B, DNS, said the PICC should have been changed as ordered and detailed instructions/interventions should have been added to the care plan.Reference WAC 388-97-1060(1-3)Reference RCW 18.88A.082

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure timely pharmacy services by not having a system in place to obtain ordered antibiotics in a timely manner, resulting in a delay in administration of prescribed antibiotics for 1 of 3 residents (Resident 1) reviewed for care and services. This placed resident at risk of prolonged infection, delay in care and a decreased quality of life. Findings include:Resident 3 was admitted to the facility on [DATE] for intravenous (via the vein) antibiotic therapy for pneumonia (lung infection). The 5-day admission MDS, dated [DATE], showed Resident 3 was cognitively intact and needed substantial assistance with ADLs. Resident 3 had a Peripherally Inserted Central Catheter (thin, flexible tube inserted into an arm vein and guided to a large vein near the heart), PICC, in their right arm. Review of the December 2025 Medication Administration Record showed Meropenem-Sodium Chloride 1 gram IV every 8 hours was ordered on 12/13/2025 and the first dose was due at 11:00PM that night. The medication was not given until 7:00AM on 12/15/2025 due to unavailability. Resident 3 had missed four doses by that time. A provider note, dated 12/19/2025, documented labs showed an increase in white blood cells (possible indication of infection) and Resident 3 reported not feeling well. Resident 3 was sent to the hospital. On 01/20/2026 at 2:00PM, Collateral Contact 1 (CC1), Social Worker at the hospital, said Resident 3 expressed frustrations with the facility due to not receiving medications and treatments as ordered. CC1 said Resident 3 feared for their well-being at the facility and had no intention of returning. On 12/29/2025 at 4:15PM, Staff B, DNS, said the PICC should have been changed as ordered and detailed instructions/interventions should have been added to the care plan. Reference WAC 388-97-1300(1)(b)(i)(ii)