

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  03/16/2026
NAME OF PROVIDER OR SUPPLIER  Olympic View Post Acute		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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review the facility failed to provide necessary assistance with personal hygiene in a timely manner and in accordance with resident preferences for 2 of 3 residents (Residents 2 and Resident 3) reviewed for quality of care. This failure placed residents at risk for un-met care needs, feelings of neglect, and discomfort. Findings included .Resident 2 Resident 2 was admitted to the facility on [DATE] due to a fall at home and subsequent lower back fractures. The re-admission Minimum Data Set (MDS, an assessment tool), dated 02/25/2026, showed Resident 1 was cognitively intact. Resident 1 needed extensive assistance for their activities of daily living (ADLs). Review of the care plan, dated 02/15/2026, showed the resident would receive a bed bath when a shower couldn't be tolerated. It did not specify how many per week or on what days. Review of the Bathing/Shower task form showed Resident 1 had not received a shower from 02/12/2026 to 03/08/2026. They had received a bed bath on 02/13/2026, 02/15/2026, 02/21/2026, 02/26/2026, and 03/08/2026. During an interview on 03/11/2026 at 2:18 PM, Resident 1 said they had not received showers or adequate bed baths since they admitted . They said the bed baths were only completed with some wet wipes and were not thorough. Resident 1 said they didn't know why they weren't getting showers but thought maybe it was due to the back fractures. Resident 1 said there hadn't been any communication from the staff. Resident 1 stated, I just feel so unclean and uncomfortable. Resident 3 Resident 3 admitted to the facility on [DATE] due to a recent left lower leg amputation. The re-admission 5-day MDS, dated [DATE], showed Resident 3 was moderately cognitively impaired and needed extensive assistance with their ADLs. Review of the care plan, dated 02/05/2026, showed Resident 2 required one to two staff members for transfers and that their nails were to be cleaned and trimmed on bath day as necessary. It did not specify how Resident 3 needed to be showered or bathed, nor did it specify the number of days per week. Review of the Bathing/Shower task form showed Resident 1 had not received a shower from 02/14/2026 to 03/07/2026. They had received a bed bath on 02/21/2026 and on 03/07/2026. During an interview on 03/11/2026 at 3:32 PM, Staff B, Unit Manager, Licensed Practical Nurse, said the task forms were accurate and there was no additional documentation. Staff B said they had noticed over the previous few weeks that residents were not receiving their showers and or baths. Staff B said the floor aides were too busy. During an interview on 03/11/2026 at 4:30PM, Staff A, Administrator, said residents should be receiving bathing services at least twice per week and preferences should be reflected on the care plan. Reference WAC 388-97-1060(1)-(3)</p>

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 0689  Level of Harm - Actual harm  Residents Affected - Few	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure the hot water used for beverage(s) were at a safe temperature for 1 of 3 residents (Resident 1) reviewed for accidents hazards. Resident 1 experienced harm when staff served them hot water directly from the dispensing machine without checking the temperature; the hot water spilled on the resident that resulted in a burn with blistering to the midline of their abdomen with reported pain and required wound care. This failure placed residents at risk for serious injury related to scalding and burns. Findings included . Consumer product safety commission publication 5098, undated, documented, Most adults will suffer third-degree burns if exposed to 150-degree [Fahrenheit F] water for two seconds. Burns will also occur with a six-second exposure to 140-degree water or with a thirty second exposure to 130-degree water. Resident 1 admitted to the facility on [DATE]. The quarterly Minimum Data Set, dated [DATE], an assessment tool, showed Resident 1 was cognitively intact. Resident was not available for interview during course of investigation. Review of an investigative report, dated 02/18/2026, showed on that day around 6PM, Resident 1 rode their motorized wheelchair to the kitchen and asked for a cup of hot chocolate. Staff E, Dietary Aide, filled a cup directly from the hot water dispensing machine, added hot chocolate mix, secured a plastic lid on top, and handed it to Resident 1. Staff E did not test the temperature of the water first. Resident 1 placed the cup in their lap and rode outside. The report documented Resident 1 had said the water spilled through the straw hole of the lid. A nursing note, dated 02/18/2026 at 7:44 PM, documented Resident 1 reported to Staff D, Wound Care Nurse, two other nurses, and a provider that they had been burnt by the hot chocolate. Resident 1 was assessed by the nurses and the provider and was found to have a 10 centimeter (cm) long and 2.5 cm wide burn with blistering to the midline of their abdomen. When asked if the resident was in pain from the burn, she said, 'a little.' On 03/11/2026 at 12:51 PM, Staff C was observed filling a cup with water directly from the dispensing machine. The temperature was immediately taken and read 180.1 degrees F. On 03/11/2026 at 12:31 PM, Staff C, Dietary Director, said the temperature of hot water directly from the machine had always been 180-degrees F. Staff C said their process was to fill several carafes with hot water and then let them sit for about an hour until the temperature dropped to 140-degrees F. Staff C said if there weren't any carafes of 140-degree F water available, staff would use water directly from the machine and add ice cubes. On 03/11/2026 at 4:15 PM, Staff D, Wound Care nurse, acknowledged that burn included blistering and that classifying it as a Stage 2 burn (partial thickness - damage to the outer and middle layers of skin) would be accurate. On 03/16/2026 at 2:50 PM, Staff E, Dietary Aide, said they just got busy and forgot to check the temperature of hot cocoa before handing it to the resident. Staff E said the cups get warped in the dishwasher and the lids don't always fit correctly. On 03/16/2026 at 4:30 PM, Staff A, Administrator, said the burn was avoidable and should not have happened. Staff A said there needed to be some changes in operations in the kitchen. Reference WAC 388-97-1060(3)(g)</p>		