

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  04/17/2026
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)		
F 0600  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.  **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to prevent, and appropriately intervene for, verbal abuse and neglect received from a staff member for 1 of 3 residents (Resident 1) reviewed for abuse. This failure placed residents at risk for emotional distress, fear, and a diminished quality of life. Findings included. An Abuse, Neglect, and Exploitation Policy, dated 08/29/2026, stated, neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. It also said that a report would be made to the appropriate agencies within two hours and an immediate and thorough investigation would be completed for any suspicion of abuse. Resident 1 was admitted to the facility on [DATE]. The quarterly Minimum Data Set (MDS, an assessment tool) showed Resident 1 was cognitively intact and dependent on staff for most of their care. On 4/17/2026 at 3:15 PM, Resident 1 said on February 2 of 2026, Staff E, Certified Nursing Assistant, came into the room to provide care. Resident 1 said they were completely dependent on staff for changing and repositioning. Resident 1 said Staff E began rummaging around in their personal drawer which did not contain hygiene products. When Resident 1 asked why Staff E was looking through the drawer, Staff E became irate and started cussing at Resident 1. Staff E told Resident 1 to change themselves and left Resident 1 exposed as they walked out the door. Resident 1 said they felt threatened when Staff E said Resident 1 should be careful about how they talk to staff that serve them food. Resident 1 said they could hear Staff E telling other aides in the hall not to provide care for them. On 04/17/2026 at 3:15 PM, CC1, Family, said on 02/02/2026 around 10:00 AM, they received a phone call from Resident 1. CC1 said the resident was very upset and tearful due to being left exposed by a care giver. CC1 said they arrived at the facility ten minutes later and found Resident 1 naked on the bed. There were no blankets on or around the bed. The call light was not within reach. CC1 requested a grievance form and gave it to Staff D, Social Service Assistant, within the hour and was told there would be an investigation. CC1 said they had to request another grievance form on 02/25/2026 as they did not believe an investigation had been completed. CC1 said Staff E would mean mug them and Resident 1 whenever they passed each other. On 04/02/2026 at 2:15 PM, Staff D said they did not remember receiving a grievance form from CC1 on 02/02/2026. On 04/02/2026 at 2:30 PM, Staff C, Social Services Director, said they received a grievance form from CC1 on 02/25/2026 and began an investigation. It was completed by 03/12/2026. Staff C said during the investigation, Staff E was found to be neglectful, unprofessional, and rude to other staff and to some residents. On 04/02/2026 at 2:38 PM, Staff A, Administrator, said they were not aware of the abuse allegation until it was reported to them on 03/13/2026 by Staff C. Staff A said Staff E was suspended on 03/11/2026 and was terminated due to the investigation results on 03/19/2026. Staff A said Staff E worked 5 shifts from 02/25/2026 to 03/11/2026. On 04/02/2026 at 3:11 PM, Staff B, Regional Registered Nurse, said the incident should have been reported within two hours, an investigation should have been started on 02/02/2026, and Staff E should have been immediately suspended. Reference WAC 388-97-0640(1)		

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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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</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 honor food preferences for 2 of 3 residents (Resident 2 and Resident 3) reviewed for dietary services. The facility also failed to provide alternative foods and failed to provide foods that were on the menu. These failures placed residents at risk for an unsatisfactory meal experience and a diminished quality of life. Findings included .Resident 2 was admitted to the facility on [DATE]. The quarterly Minimum Data Set (MDS, an assessment tool), dated 01/26/2026 was cognitively intact and was able to make their own choices regarding meals. On 04/01/2026 at 1:44 PM, Resident 2 was observed in their room with a lunch tray. The plate had a large helping of cut up red beets. Resident 2 pointed at their meal slip which had beets typed under the dislikes section. Resident 2 said they would often receive foods they did not like and would have to ask for a peanut butter and jelly sandwich instead. Resident 2 said they had repeatedly talked to Staff A about the problems regarding food service. Resident 3 was admitted to the facility on [DATE]. The quarterly MDS, dated [DATE], showed Resident 3 was cognitively intact and was able to make their own choices regarding meals. On 04/01/2026 at 1:10 PM, Resident 3 was observed with a lunch tray that had mashed potatoes on it. Resident 3 said that was surprising because, usually, if rice was on the menu, that is what they would receive. Resident 3 pointed to the meal slip on the tray that had rice typed under the dislikes section. Resident 3 said they would often order off the bistro menu but would still receive the main meal. Resident 3 said the menu was incorrect for four of seven days of the previous week. On 04/01/2026 at 5:30 PM, the menu of the day was observed outside of the dining room. Residents were supposed to have spiced pears but bowls on the trays contained orange colored fruit and whipped topping. On 04/01/2026 at 5:33 PM, Staff F, Dietary Aide, said the fruit was mangos. When asked why mangos were served instead of spiced pears, Staff F said that happened frequently. Staff F said the day shift would just make what they had on hand for the dinner staff to serve and, oftentimes, it was not what was on the menu. On 04/02/2026 at 2:38 PM, Staff A, Administrator, said they had to let the dietary manager go a couple of weeks prior. Staff A said another kitchen staff member was filling in but said there were starting to be some issues. Staff A said residents should not be receiving foods that are on their dislikes/allergy's lists. Staff A said residents should be able to order and receive food off of the alternate menus. Staff A said the food served should be on the menu, and if changes needed to be made, that residents should be notified beforehand. Reference WAC 388-97-1120(3)(a)</p>		