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	05/21/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, interview, and record review the facility failed to prevent 4 of 4 residents (Resident 1, Resident 2, Resident 3, and Resident 4) from experiencing sexual abuse and or neglect at the hands of staff and or of other residents. This failure placed residents at risk of injury, psychosocial harm, and a diminished quality of life.Findings included.An Abuse, Neglect and Exploitation Policy, dated 08/29/2026, defined Sexual Abuse as non-consensual sexual contact of any type with a resident. It defined Neglect as 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.Sexual AbuseResident 1 admitted to the facility on [DATE]. The quarterly Minimum Data Set, (MDS, an assessment tool) showed Resident 1 was severely cognitively impaired. Resident 1 had a history of trauma, neglect, and dementia.Resident 2 admitted to the facility on [DATE]. The quarterly MDS, dated [DATE], showed Resident 2 was cognitively intact. Resident 2 had a history of a significant stroke that caused aphasia (inability to speak) and poor impulse control.On 05/20/2026 at 1:20PM, Staff E, Certified Nursing Assistant, said on one of the days earlier in the week, they had observed Resident 2 bringing a dish of ice cream into Resident 1's room. Staff E said when they passed by the room a few minutes later, they observed Resident 2 had their hand placed on the inside of Resident 1's thigh. Staff E said they did not report the observation to anyone. Staff E said a few days later on 05/19/2026 at approximately 10:30AM, they went into Resident 1's room and observed Resident 1 and Resident 2 involved in mouth to mouth kissing. Staff E said they observed both residents had their hands in each other's genital area. Staff E said they stopped the interaction when they saw Staff E enter the room. Staff E reported the interaction to the nurse.On 05/20/2026 at 12:15PM, Staff A, Administrator, said Resident 2 did not have a history of any sexual aggression. Staff A said Resident 2 was very friendly and liked to give hugs to staff and other residents.Resident 2's care plan, dated 01/20/2025, documented Resident 2 showed sexually disinhibited behaviors, including kissing, hugging, and boundary violations. It said Resident 2 may have difficulty regulating emotions which could place others at risk.On 05/20/2026 at 12:30PM, Staff B, Director of Nursing Services (DNS), said Staff E should have reported the first observation so that interventions could have been immediately put into place. Staff B said Resident 1 did not have the mental capability to consent to sexual interactions. Staff B said Resident 2 should have had closer monitoring and interventions for their hugging and touching behaviors.NeglectResident 3 admitted to the facility on [DATE] with a diagnosis of a heart attack requiring open heart surgery. The admission 5 day MDS, dated [DATE], showed Resident 3 was cognitively intact.On 05/19/2026 at 10:12AM, Resident 3 said they were in a lot of pain on the night of 05/01/2026 and had asked for the 11:00PM dose of Tramadol (opioid pain killer used to treat moderate to severe pain). Resident 3 said Staff F, Registered Nurse, took their blood pressure and then told them the dose could not be administered due to the pressure being too low. Resident 3 asked for a dose of Tylenol at around 3:00AM but did not receive it until 6:10AM. Resident 3 said they were in tears at that point.Review of the pain care plan, dated 05/04/2026, showed Resident 3 had the potential for pain. Interventions included, Administer (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	analgesia as per orders and discuss concerns regarding pain management with the provider and consulting pharmacist as needed.Review of the May Medication Administration Record showed Resident 3's blood pressure at 11:00PM was 107/63. The parameters for administration of Tramadol read to hold the medication if blood pressure was under 100.On 05/20/2026 at 4:30PM, Staff B, DNS, said their investigation showed Staff E was neglectful due to not administering the medication as ordered. Staff B said if Staff E was concerned about the blood pressure, they should have called the on-call provider to see if there was something else that could be given.Staff E was no longer employed with the facility and unavailable for interview.Resident 4 was admitted to the facility on [DATE]. The annual MDS, dated [DATE], showed Resident 4 was cognitively intact and needed moderate assistance for activities of daily living.Review of the self-performance care plan, dated 03/31/2025, showed Resident 4 needed 1 person to assist them with transfers including using the bathroom.On 05/21/2026 at 11:10PM, Resident 4 said Staff C, Certified Nursing Aide, had left them in the bathroom a few weeks ago. Resident 4 said they had gone into the bathroom themselves and transferred to the toilet. Resident 4 said they called for help to get off the toilet from Staff C who was in the room assisting their roommate. Staff C helped them stand then walked away. Resident 4 said they fell and bruised their chest. Resident 4 said the toilet was too low and that they had expressed this frustration to several staff members.On 05/21/2026 at 11:20PM, Staff D, Director of Rehabilitation, said falls were discussed at stand ups every day. If it was deemed necessary, the rehab department would do an assessment and come up with interventions to prevent further falls. Staff D said this fall should have been evaluated by their department but that they had not been informed of the fall.On 05/21/2026 at 11:25PM, Staff B, DNS, said Staff C did not report the fall. Staff B said they found out from Resident 4 about a week later. Staff B did not ask for an evaluation from the rehabilitation department. Staff B said Resident 4 should not have been left alone in the bathroom.Staff C was no longer employed with the facility and was unavailable for interview.Reference WAC 388-97-0620(1)