

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/08/2026
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 - 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 3 of 3 residents (Resident 1, Resident 2, and Resident 3) from experiencing neglect from nursing staff. This failure placed residents at risk for injury, unmet care needs, and a diminished quality of life. Findings included. An Abuse, Neglect and Exploitation Policy, dated 08/29/2026, 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. Resident 1 Resident 1 admitted to the facility on [DATE]. The quarterly Minimum Data Set (MDS), an assessment tool, dated 01/02/2026, showed Resident 1 was cognitively intact. Review of the Activities of Daily Living Self Care Performance care plan, dated 03/26/2026, showed Resident 1 required two persons utilizing a sit to stand lift (a mobility aid designed to help individuals transition safely from seated position to a standing position) for transfers. On 07/08/2026 at 3:30PM, Resident 1 said they were dropped from the sit to stand lift about 10 days prior. Resident 1 said Staff C, Certified Nursing Assistant (CNA) was the only one working with the lift. Resident 1 said Staff C repositioned the straps several times and then attempted to have them stand. Resident 1 said they slid down to the ground and bruised both their knees and pulled their shoulder and neck. They said Staff C then left the room to get help. On 07/08/2026 at 3:40PM, Staff A, Director of Nursing (DNS) said Staff C, CNA, did not report the incident and that they only became aware when Resident 1 told them about it a few days later. Staff A said Staff C did not follow the care plan and should not have used the lift without another staff member. Resident 2 Resident 2 admitted to the facility on [DATE]. The 5-day admission MDS showed Resident 2 was moderately cognitively impaired. Review of the care plan, dated 06/24/2026, showed Resident 2 was at risk for falls related to not being aware of safety needs. It showed Resident 2 was at risk for injury and or bleeding related to being on an anticoagulant (prevents blood clots) therapy for a history of pulmonary emboli (blood clots in the lungs). On 07/08/2026 at 4:33PM, Resident 2 said they had a fall from the bed to the floor a few weeks prior. They said they had hurt their right hip and leg and had hit their face. Resident 2 said the aides helped them back to bed but that they were never seen by the nurse. On 07/08/2026 at 4:45PM, Staff A, DNS, said Staff D, Registered Nurse (RN) did not complete an incident report until two days after the incident. Staff A said when they came to work on Monday, June 22, they had several grievances and complaints about Staff D regarding neglect of residents as Staff D had worked the weekend prior. Staff A said an incident report and a nursing assessment should be completed at the time of the incident. Resident 3 Resident 3 admitted to the facility on [DATE]. The quarterly MDS, dated [DATE], showed Resident 3 was cognitively intact. Review of a nurse's note, dated 05/28/2026, showed Resident 3 had a witnessed fall and was sent to the hospital. Resident 3 was found to have fractures to their right foot which required 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cast.On 07/08/2026 at 2:15PM, Resident 3 said they had completed a grievance on 06/21/2026 about Staff D, RN. Resident 3 said Staff D was walking down the hall talking on their cell phone and accidentally hit Resident 3's right foot. Resident 3 said they cried out as it was painful and that Staff D said sorry but did not stop to assess the situation. Resident 3 said Staff D was often rude and dismissive.On 07/08/2026 at 2:45PM, Staff B, Assistant Director of Nursing, said they had investigated the grievance from Resident 3 and had completed a formal reprimand. Staff B said Staff D, RN, was not acceptive of the reprimand and refused to sign the document. Reference WAC 388-97-0640(1)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review, the facility failed to make a reasonable effort to uncover information about prospective employees by not completing reference checks for 3 of 3 employees (Staff D, Staff E, and Staff F) reviewed for implementation of abuse and neglect policies. This failure placed residents at risk for unmet care needs and services and a diminished quality of life. Findings included .Staff D was hired by the facility on 05/06/2026 as a Registered Nurse. Staff E was hired on 07/01/2024 as a Student Nurse. Staff F was hired on 07/16/2016 as a Certified Nursing Assistant. Review of the facility's personnel files showed neither Staff D, Staff E, nor Staff F had reference checks completed before they were hired or during their employment. On 07/08/2026 at 4:35PM, Staff A, Director of Nursing Services, said reference checks should be completed for all employees as part of the hiring process. Reference WAC 388-97-0640(2)(a)(b) Reference F600		