

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505390	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2024
NAME OF PROVIDER OR SUPPLIER McKay Healthcare & Rehab Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 127 Second Avenue Southwest Soap Lake, WA 98851	

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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45642</p> <p>Based on observation, interview, and record review the facility failed to ensure a severely cognitively impaired resident was free from non-consensual sexual abuse for 1 of 4 residents (Resident 2) reviewed for sexual abuse. The failure to adequately supervise Resident 1 with their known pattern of inappropriate sexual behaviors toward female residents caused Resident 2 to experience psychosocial harm, applying the reasonable person approach, when facility staff did not provide timely supervision for a resident with a known history of sexually inappropriate behaviors. Resident 1 was observed interacting with Resident 2 in a nonconsensual sexually inappropriate manner. This failure also placed all residents at risk for sexual abuse.</p> <p>Findings included .</p> <p>Review of the facility' policy titled Abuse, Neglect, and Exploitation Policy, dated 09/10/2023, showed the definition of sexual abuse was nonconsensual sexual contact of any type with a resident.</p> <p>Review of the State Operations Manual (SOM), dated 03/06/2019, page seven, showed in psychosocial vulnerable situations,the reasonable person approach could be considered in the determination of psychosocial harm. In other words, consider if a reasonable person in a similar situation could be expected to experience a serious adverse outcome as a result.</p> <p>Additionally, the SOM defines Sexual abuse at 483.5 as nonconsensual sexual contact of any type with a resident. Generally sexual contact is nonconsensual if the resident lacks the cognitive ability to consent.</p> <p><Resident 2></p> <p>Review of the electronic medical record showed Resident 2 was admitted to the facility on [DATE]. Resident 2 had diagnoses including Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and the ability to carry out simple tasks), anxiety (a feeling of worry, nervousness, or unease), and insomnia (a sleep disorder that makes it hard to fall asleep, stay asleep, or get quality sleep). Further record review showed Resident 2's cognition was severely impaired.</p> <p>(continued on next page)</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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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 2's most current comprehensive assessment dated [DATE], showed the resident was dependent (a person that relies on staff do all the work due to the resident's inability to put forth effort or complete the activity at hand) on staff for their personal hygiene, dressing, toileting, transfers, and bed mobility. The resident required supervision or touching assistance with eating.</p> <p>Review of the care plan dated 05/23/2024 showed Resident 2 was not capable of making their own healthcare decisions and/or giving informed consent (the ability to understand/comprehend important information about their health/wellness and the possible risk/benefits of medical treatment in order to make an informed decision).</p> <p>During a concurrent observation and interview on 06/26/2024 at 3:44 PM Resident 2 was in the dining room participating in bingo activities, when bingo numbers were called out the resident had trouble identifying the correct number. When greeted Resident 2, responded to their name, was unable to comprehend questions being asked or respond/hold a meaningful conversation.</p> <p><Resident 1></p> <p>Review of the electronic medical record showed Resident 1 was admitted to the facility on [DATE]. Resident 1's diagnoses included a compression fracture (collapsing the bone in the front of the spine and leaving the back of the same bone unchanged), bipolar disorder (a brain disorder that causes changes in a person's mood, energy, or ability to function).</p> <p>Review of Resident 1's most current comprehensive assessment dated [DATE], showed the resident was cognitively intact, able to make their needs known, was easily understood by staff, and had the ability to express their ideas/wants with clear comprehension. Once Resident 1 was assisted into their wheelchair they were able to self-propel throughout the facility and no functional limitation of their upper and lower body.</p> <p>Review of an incident investigation report dated 06/10/2024 showed Resident 1 (a male resident 12 inches taller in stature to Resident 2) was in the dining room sitting in their wheelchair next to Resident 2 (a smaller female resident) who was also in their wheelchair. Resident 1 was being very friendly (towards Resident 2). Staff D, Registered Nurse (RN), after administering another residents medication, returned to the dining room to observe Resident 1 (a male who was 12 inches taller in stature than Resident 2) had proceeded to maneuver their wheelchair into a position that had blocked Resident 2 (so that Resident 2's back was up against a table. Resident 1 was facing Resident 2 with their legs together .(Resident 1's) legs touching (Resident 2's) legs and had (Resident 2's) hand in (Resident 1's) lap, and (Resident 1) was giggling. Staff C, Social Services Director, conducted an interview with Resident 1 on 06/13/2024 where the resident stated they did not remember the incident or the other resident involved, .but I must have liked it.</p> <p>Further review of incident investigation report showed on 06/15/2024, Staff C was stopped by Resident 1 to discuss the incident further. Staff C stated that Resident 1 was defensively stating that the incident was by both consenting adults .I got a raging erection, I provoked it, but (Resident 2) seemed fine .it was uncomfortable and I put the tip out of my waistband . Staff C stated that Resident 1 was aware that the other resident involved in the incident was Resident 2 and Staff C informed Resident 1 they should not be exposing themselves to other residents. Additionally, Staff C stated that Resident 2 was not cognitively able to make those kinds of decisions.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident 1's progress notes from February 2024 through June 2024, showed that Resident 1 had multiple episodes of sexual inappropriate behaviors as follows:</p> <p>On 02/10/2024 at 12:45 PM, Staff H, RN, documented that (Resident 1) asked another resident if (Resident 1) could touch (unidentified female residents) b**oobs in the dining hall and that Resident 1 was educated on sexually inappropriate behaviors.</p> <p>On 05/13/2024 at 1:06 AM, showed Staff D, RN observed Resident 1 came out into the hallway after dinner and sat next to an unidentified female in their wheelchair. Resident 1 was observed reaching towards the unidentified female's lap.</p> <p>On 06/10/2024 at 7:47 PM, showed Staff D, observed Resident 1 in the dining room with Resident 2 being very friendly. Staff D documented (Resident 1) had maneuvered their wheelchair to block (Resident 2's) wheelchair so (Resident 2's) back was to table.</p> <p>During an interview on 06/26/2024 at 1:04 PM, Resident 1 stated they remembered the incident with Resident 2 on 06/10/2024.</p> <p>Resident 1 stated they were sitting in the dining room with Resident 2. Resident 1 claimed Resident 2 had lifted their shirt and exposed their breast to Resident 1, What is a man to do? Resident 1 stated, one thing led to another and that Resident 2 had consented but, nothing really happened. Further, as far as I'm concerned the incident has been blown out of proportion.</p> <p>During an interview on 06/26/2024 at 1:07 PM, Staff E, Nursing Assistant, NA, stated they were aware of Resident 1's inappropriate behaviors back when they were first admitted .</p> <p>During an interview on 06/26/2024 at 1:41 PM, Staff C, stated they had spoke with Resident 1 about the incident on 06/10/2024 and initially Resident 1 stated they were unable to remember anything about the incident. Staff C stated then three days later, Resident 1 communicated they had gotten an erection and let the tip out of their waist band and that Resident 2 had given consent. Staff C then stated they had informed Resident 1 that Resident 2 was unable to give consent due to their dementia.</p> <p>During an interview on 06/26/2024 at 2:34 PM, Staff G, Licensed Practical Nurse (LPN), stated Resident 2 had a hard time focusing and staying on task due to their dementia, (Resident 2) is not real with it (meaning they were cognitively impaired). Staff G stated that Resident 2 could not hold a meaningful conversation for any length of time. Staff G further explained that Resident 2 would not be able to give an informed consent such as if the resident were to get a new medication, they would not be able to understand why or what the medication was for. Staff G stated that Resident 1 had no impulse control and that they themselves have been subjected to Resident 1's inappropriate behaviors before, when Resident 1 inquired about the staff members tattoos which led to Resident 1 stating do you have tattoos on your boobs too? Additionally, Staff G stated they keep at eye on (Resident 1), but there had been no implementation of one-on-one supervision (a method where an individual staff member stays close to a resident to ensure constant supervision and immediate intervention for safety reasons) for Resident 1.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/27/2024 at 9:36 AM, Staff D, RN, stated, I feel like Resident 1 is a predator (a person who hurts or takes advantage of others for personal gain) .their behavior usually happens after dinner, when the (Nursing Assistants, NA) are busy, and nurses are passing their medications. Staff D stated, on 06/10/2024 they peeked into the dining room, observed Resident 1 entering/self-propelling their wheelchair. Staff D stated that Resident 1 did not usually socialize after dinner. Then Staff D stated, they felt an urgency, to quickly finish administering some medications that were in their hands since they had concerns about Resident 1's intentions and being alone in the dining room with a female resident. When Staff D returned to the dining room, they observed Resident 1 had maneuvered Resident 2's wheelchair so Resident 2's back was against the table, (Resident 1's) knees against (Resident 2's) knees .(Resident 2) couldn't go forward or back, (Resident 2) couldn't get away. Staff D stated that Resident 2 was totally unaware of the situation and (Resident 1) had no shame (meaning that Resident 1 remorseful about their sexually inappropriate actions). Staff D stated .I did not call the police, or the power of attorney. I wrote my progress note.</p> <p>During an interview on 06/26/2024 at 4:49 PM, Staff A, Administrator, and Staff B, Director of Nursing Services, both stated that Resident 2 was not cognitively aware enough to make decisions. Both staff stated they had not implemented one-on-one supervision for Resident 1, but that Resident 1 was being watch more closely so they are not alone with the opposite sex. Additionally, Staff A and Staff B stated that Resident 1 did have a history of sexually inappropriate behaviors towards females.</p> <p>Reference: WAC 388-97-0640 (1)</p>		