STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505390	A. Building B. Wing	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McKay Healthcare & Rehab Ctr	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40297 Based on observation, interview, and record review, the facility failed to ensure the staff implemented safe transfer technique during the operation of a mechanical lift for 1 of 3 (Resident 1) sampled residents reviewed for accidents. This resulted in Resident 1 experiencing a fall from a mechanical lift and a transfer to the hospital for further evaluation. Findings included . An undated and modified facility policy titled Safe Resident Handling/Transfers showed, two staff members must transfer residents with a mechanical lift. The policy directed the staff to position the resident in preparation for the transfer and apply, adjust, and secure the lift sling according to the manufacturer's guidelines. The policy instructed the staff that if a sit-to-stand lift [a lift that required the resident to bear some of their own weight and participate actively in the transfer] was used, to additionally secure the resident by buckling up the lift sling around the resident's waist prior to the transfer. Review of an 11/08/2024 comprehensive assessment showed Resident 1 admitted to the facility on [DATE] with a progressive neurological condition. The assessment showed the staff assessed Resident 1's cognition was severely impaired and dependent on the staff for transfers. Review of a 02/06/2024 care plan intervention showed Resident 1 was not able to pull [themselves] up to a standing position with one person assist. This intervention instructed the staff to transfer the resident with the use of a sit to stand lift with 2 person assist. An observation on 01/03/2025 at 10:17 AM showed two staff transferred Resident 1 from their wheelchair to the restroom in a sit-to-stand lift. Closer observation showed a dark purple bruise extending from the side of Resident 1's left elbow to the middle of the forearm, approximately 6 inches by 3 inches in size. Review of a 12/31/2024 progress note showed a nurse was called to Resident 1's room. The note showed that the nurse found Resident 1 face down on the floor and fell in mid-transfer from bed to wheelchair via sit to stand. The note showed the staff had Resident 1 transferred to the hospital for further evaluation. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a 12/31/2024 emergency room Summary showed Resident 1 presented to the emergency room with face and arm pain. The summary showed Resident 1 experienced a fall with a resulting cut inside the mouth and bruising to the upper gums and left upper arm. The notes showed there was no serious traumatic injury. Resident 1 was discharged back to the facility in stable condition that same day. Review of a 12/31/2024 facility investigation showed Resident 1 experienced a fall from the sit-to-stand lift the morning of 12/31/2024. The investigation showed Staff C, Agency Nursing Assistant (NA), and Staff D (Agency NA) were involved in Resident 1's transfer from the bed to the wheelchair the morning of the fall. In an interview on 01/07/2024 at 1:41 PM, Staff C stated that after providing personal cares to Resident 1 with the help of Staff D, they assisted the resident to sit at the edge of the bed, then stood the resident up with the sit-to-stand lift. Staff C stated that after the resident was assisted to a standing position, [Staff D] left me to go get other residents up. Staff C described Resident 1 then leaned forward and slowly slid off the foot plate of the sit-to-stand and, I was in shock, confused, and didn't know what to do so, I laid [the resident] on the floor. Staff C stated that they did not remember seeing the lift sling buckle secured around the resident's torso. Staff C stated, I didn't put the sling on [the resident], it was the other aide. Staff C stated that it was required to have two people present during a mechanical lift transfer, To keep an eye out for the resident in case like accidents like this, for safety reasons. Staff C stated that some of the things they would do to prevent a fall from a mechanical lift included, Double check everything. Like for future reference, make sure, be cautious. After this incident I would never be too sure, and double check. In an interview on 01/03/2024 at 2:37 PM, Staff D stated that when they were returning to Resident 1's room, they saw Staff C, ran out into the hall and said [Resident 1] fell . Staff D stated that when they entered the room, Resident 1's face was down and arms were up and, did not have the buckle on, just the sling around [their] back. Staff D stated, The buckle is for safety so they can't slip or fall. In an interview on 01/03/2025 at 11:11 AM, Staff B, Director of Nursing, stated that the investigation deducted, The lower waist belt was not buckled. Staff B acknowledged Staff C and Staff D did not follow the intervention that instructed the staff to transfer the resident with 2 person assist during the use of a sit-to-stand lift. The above findings were shared with Staff A, Administrator, on 01/07/2025 at 10:14 AM. Staff A stated the staff, did not follow the care plan. If [they] did what was supposed to be done, that could have prevented it [the fall]. Refer to F726. Reference WAC 388-97-1060 (3)(g).

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 40297 Based on observation, interview, and record review, the facility failed to ensure 4 of 5 (Staff C, D, E and F) sampled agency (contracted) staff whose personnel files were reviewed, showed established proficiency with the operation of mechanical lift transfers prior to or at the time of assignment to the facility. This failure placed the residents at risk for falls and their associated injuries. Findings included . Review of an undated and modified facility policy titled Safe Resident Handling/Transfers showed, two staff members must transfer residents with a mechanical lift. The policy directed the staff to position the resident in preparation for the transfer and apply, adjust, and secure the lift sling according to the manufacturer's guidelines. The policy instructed the staff that if a sit-to-stand lift [a lift that required the resident to bear some of their own weight and participate actively in the transfer] was used, to additionally secure the resident by buckling up the lift sling around the resident's waist prior to the transfer. Review of a 02/06/2024 care plan intervention showed Resident 1 was not able to pull [themselves] up to a standing position with one person assist. This intervention instructed the staff to transfer the resident with the use of a sit to stand lift with 2 person assist. Review of a 12/31/2024 facility investigation showed Resident 1 experienced a fall from the sit-to-stand lift the morning of 12/31/2024 and required a hospital transfer for further evaluation. The investigation showed Staff C, Agency Nursing Assistant (NA), and Staff D (Agency NA) were involved in Resident 1's transfer from the bed to the wheelchair the morning of the fall. In an interview on 01/07/2024 at 1:41 PM, Staff C stated, It hasn't even been a month, a couple of weeks [working with the staffing agency]. Staff C shared they recently completed their NA training then went to work directly with the staffing agency. Staff C recalled being exposed once to the use of a Hoyer lift (a lift that allows a resident to be fully lifted and transferred with no physical effort, unlike a sit-to-stand) at a different facility. Staff C was asked if they knew what the facility policy was regarding the use of a mechanical lift transfer and stated, No, not really. I don't know. When asked if they received any training on the use of mechanical lifts at the facility, Staff C stated, The first time I arrived [at the facility] another aide gave me a packet that had all that resident information, like a rundown of my residents and the assistance they needed, and what time I get my breaks and that's everything. Staff C stated that Staff D left them alone in the room with Resident 1 in a standing position in the sit-to-stand. Staff C described Resident 1 then leaned forward and slowly slid off the foot plate of the sit-to-stand and, I was in shock, confused, and didn't know what to do so, I laid [the resident] on the floor. Staff C stated that they did not remember seeing the lift sling buckle secured around the resident's torso. Staff C stated, I didn't put the sling on [the resident], it was the other aide. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 01/03/2024 at 2:37 PM, Staff D stated that when they were returning to Resident 1's room, they saw Staff C, ran out into the hall and said [Resident 1] fell . Staff D stated that when they entered the room, Resident 1's face was down and arms were up and, did not have the buckle on, just the sling around [their] back. Staff D stated, The buckle is for safety so they can't slip or fall. In an interview on 01/03/2025 at 11:11 AM, Staff B, Director of Nursing, was asked if the facility verified Staff C and Staff D were proficient in the use of mechanical lift transfers prior to their assignment or upon their arrival to the facility. Staff B stated that they received no records from the staffing agency and that, We get their basics [information] to verify their licenses and No, we didn't do our competencies or orientation [with Staff C and Staff D]. In an interview on 01/07/2025 at 9:32 AM, Staff G, Staffing Coordinator, stated that once they confirmed an agency aide was available for open shifts, they requested a Caregiver Profile (CP) from the staffing agency. The CP included, background checks, licenses, immunizations, work history, and references. Staff G stated that a proficiency skills checklist was automatically included with the CP and if it wasn't, they would request it. Staff G stated that once they received the CP, they reviewed it, forwarded it to the Human Resources Department, then scheduled the aide to work. Staff G stated that orientation of agency staff in the facility included providing knowledge of assignment and supply's locations, a little bit on the residents, and was not based on the proficiency skills checklist received from the staffing agency. In the continued interview of 01/07/2025 at 9:32 AM, Staff G stated Staff C, was super new to our facility, and worked two shifts, on 12/20/2024 and 12/31/2024 (the day of the fall). Staff G requested Staff C's proficiency skills checklist from the staffing agency on 01/03/2024, three days after the fall and 15 days after the initial day of work. In the continued interview of 01/07/2025 at 9:32 AM, Staff G confirmed Staff D worked in the facility on 12/02/2024, 12/03/2024, 12/05/2024, 12/09/2024, 12/11/2024 12/14/2024, 12/15/2024, 12/21/2024, 12/22/2024, 12/24/2024, 12/25/2024, 12/28/2024, 12/30/2024, and 12/31/2024. Review of the CP with Staff G showed no documentation the facility established Staff D's skills proficiency. In the continued interview of 01/07/2025 at 9:32 AM, Staff G stated that the facility employed a total of 21 agency NA. Staff E worked on 12/13/2024 and accepted assignments in the facility since 04/26/2024. Staff F worked on 12/14/2024 and accepted assignments in the facility since 04/07/2024. Review of the CP with Staff G showed no documentation the facility established Staff E's or Staff F's proficiencies. In an interview on 01/03/2025 at 11:35 AM, Staff A, Administrator, stated that agency staff proficiency, should be obtained and confirmed prior to their coming to work or at the time of their shift. Absolutely, like ASAP [as soon as possible]. No further information was provided. Refer to F689. Reference WAC 388-97-1080 (1), -1090 (1), -1680 (2)(a)(b)(i-ii)(c).