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 03/18/2026

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** Based on observation, interview and record review, the facility failed to implement the resident elopement protocol for 1 of 3 residents (Resident 1) reviewed for accidents. This failure placed the resident at risk for possible serious injury related to an elopement (the potential danger when a resident, often deemed impaired to make sound decisions, leaves the facility premises or safe area unauthorized, posing immediate threats to their health or safety). Findings included .Review of the facility policy dated 08/16/2023 titled, Elopement and Wandering Residents, showed the definition of Suspected Elopement occurs when there is reasonable evidence that a resident has eloped or a resident's whereabouts are not immediately known. Further review showed that any staff member becoming aware of or suspecting a missing resident will alert personnel using facility approved protocol (internal alert code). Resident 1 Review of the medical record showed Resident 1 was admitted to the facility on [DATE] with diagnoses to include chronic obstructive pulmonary disease (a common lung disease causing restricted airflow and breathing problems), depression (a mental health condition characterized by persistent sadness and a loss of interest in activities for long periods of time) and chronic pain. The comprehensive assessment dated [DATE], showed the resident required supervision or touching assistance with walking and that their cognition was intact. Review of a history and physical, dated 10/20/2025, showed Resident 1 had a polysubstance abuse disorder (a condition where a person compulsively uses three or more different classes of drugs or substances over a 12-month period, often without a primary preference for one specific substance). Review of an elopement risk assessment for Resident 1, dated 10/22/2025, showed an elopement risk score of five (moderate risk) of leaving the facility. Review of the care plan dated 12/19/2025 did not show an elopement care plan for Resident 1. Review of the facility's visitor sign-in sheet dated 03/07/2026 showed Resident 1 had a family member visit at 11:30 AM on that day. There was no sign-out time from the family member or Resident 1. Review of the facility's incident logs dated January 2026 through 03/18/2026, showed Resident 1 was a missing resident/elopement on 03/08/2026 at 8:00 AM. In an interview on 03/18/2026 at 12:30 PM, Staff D, Licensed Practical Nurse, stated they were assigned to Resident 1 on 03/07/2026 and administered their morning medications between 6:00AM to 7:00 AM. Staff D stated they went into Resident 1's room to administer their 1:00 PM medications and the resident was not there. Staff D stated the roommate said Resident 1 had gone to lunch with their family member. Staff D stated they did not call the family to verify the resident was with them. Staff D stated they were not aware of a time frame to call a resident or family member of when they would return to the facility. Staff D stated that Resident 1 did not come back on their shift (6:00 PM was the end of their shift, five hours after Resident 1 was missing from the facility). Staff D stated they did not implement the missing resident/elopement protocol. Review of Resident 1's progress notes, dated 03/08/2026, showed documentation of the resident missing at 8:30 AM on that day, when the dayshift nurse noticed Resident 1 was not in bed for their scheduled morning medications. The nurse had called the family and found the resident had been dropped off at the facility on 03/07/2026 (the previous day) at 2:00 PM in the parking lot. The progress notes further showed the (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nurse implemented the missing resident/ elopement protocol at that time (18 hours after Resident 1 was missing from the facility). During an interview on 03/18/2026 at 1:35 PM, Staff A, Administrator, stated the facility had an agency nurse working at the time of the incident and nothing had been done when Resident 1 was missing until the next day. Staff A stated Resident 1 was found by the water (about half of a mile from the facility) and was sent to the local hospital for evaluation. Reference: WAC 388-97-1060 (3)(g)