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	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McKay Healthcare & Rehab Ctr	127 Second Avenue Southwest Soap Lake, WA 98851

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117 Based on observation, interview, and record review, the facility failed to provide care and services in a manner that promoted resident respect and dignity for 3 of 4 residents (Residents 14, 27, and 29) reviewed for resident rights. This failure placed the residents at risk for distress, embarrassment, and an undignified existence. Findings included . Review of a policy titled, Resident Rights, edited 10/28/2024, showed the resident had the right to self-determination and a dignified existence. <Resident 14> Review of the medical record showed Resident 14 was admitted to the facility with diagnoses including Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), difficulty speaking, and difficulty swallowing. The 02/06/2025 comprehensive assessment showed Resident 14 was dependent on one to two staff members for activities of daily living (ADLs). The assessment also showed Resident 14 was able to make their needs known. An observation on 03/17/2025 at 10:09 AM, showed Resident 14 sitting in their wheelchair in the hallway outside of restroom [ROOM NUMBER], waiting to use the restroom. Restroom [ROOM NUMBER] had a door that opened into the restroom and a privacy curtain hanging across the doorway. Resident 14 was assisted into the restroom by Staff F, Nursing Assistant (NA), and Staff H, NA. Staff H exited the restroom and closed the privacy curtain. Staff F was overheard talking to Resident 14 about their toileting needs. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 03/18/2025 at 9:36 AM, showed Resident 14 sitting in their wheelchair in the hallway outside of restroom [ROOM NUMBER]. There were two additional residents in the hallway waiting in line to use the restroom. Resident 14 was transferred into the restroom and on to the toilet by Staff D, NA, and Staff E, NA, using a mechanical lift (a device to safely lift and move people who can not stand or walk on their own). The curtain was pulled closed, leaving a three-inch gap between the wall and the curtain. Staff D told Staff E they needed to get a brief for Resident 14. Staff E exited the restroom and stated to Staff F, NA, the resident was on the toilet and walked down the hall towards Resident 14's room. At 9:42 AM, Staff E returned to the restroom, opened the curtain, and entered the restroom with Resident 14 ' s brief. The toilet was flushed, and Resident 14 was brought out of the restroom on the mechanical lift. A strong odor of feces was noted in the hallway. During an interview on 03/20/2025 at 11:04 AM, Resident 14's representative (RR) stated the restroom in the hallway (#104) was ridiculous (small and not private). They stated there was another restroom (#110) just down the hall that was larger, and the door could be shut. The RR stated they had always had an issue with privacy in the small restroom (#104) and stated the lack of privacy would be an issue for Resident 14 as well. <Resident 27> Review of the medical record showed Resident 27 was admitted to the facility with diagnoses including a stroke, kidney disease, and dementia (a progressive disease that destroys memory and other important mental functions). The 01/31/2025 comprehensive assessment showed Resident 27 was dependent on one to two staff for ADLs and had a severely impaired cognition. During an observation on 03/18/2025 at 9:48 AM, Staff D and Staff F transferred Resident 27 to restroom [ROOM NUMBER] using a mechanical lift. The privacy curtain was pulled, and the door was not shut. Toileting cares could be overheard from the hallway. During an interview on 03/18/2025 at 9:57 AM, Staff G, NA, stated they used restroom [ROOM NUMBER] for toileting residents because it was larger and safer area for toileting the residents that used a mechanical lift. They stated they were able to provide privacy by shutting the door. Staff G stated staff preferred to use the smaller restroom (#104) for convenience. During an interview on 03/18/2025 at 10:05 AM, Staff D stated they used the smaller restroom (#104) because it was quicker to toilet the residents that used a mechanical lift. Staff D stated they should always close the door for privacy. During a concurrent observation and interview on 03/20/2025 at 10:27 AM, showed Staff E and Staff I, NA, exiting the small restroom (#104) after assisting a resident with toileting. Staff E stated they preferred to use the smaller restroom for residents on a mechanical lift because it was quicker. Staff I stated they would not be comfortable going to the bathroom with just this curtain for privacy. Staff E stated they were able to close the door, when the lift was not in the bathroom. They stated they would have to take the lift out if they wanted to close the door. Staff E stated they closed the curtain for privacy. <Resident 29> (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record showed Resident 29 was admitted to the facility with diagnoses including neurocognitive disorder with Lewy bodies (a progressive disease that causes memory loss, tremors, stiffness, anxiety, depression, and sleep disorders), Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), and presbyopia (gradual loss of the eye's ability to focus on nearby objects). The 02/13/2025 comprehensive assessment showed Resident 29 was dependent on one to two staff for ADLs. The assessment also showed Resident 29 had a severely impaired cognition and wore corrective lenses. Resident 29 was receiving palliative care (patient centered care that optimizes the quality of life by addressing physical, emotional, and social needs, and facilitates access to information and patient choice) during the assessment period. During a concurrent observation and interview on 03/17/2025 at 1:04 PM, showed Resident 29 sitting in their wheelchair in a private dining area with their representative, eating their meal. Resident 29 was wearing their glasses that had visible deterioration to both lenses. Resident 29's Representative (RR) stated the resident wore glasses but needed to have them replaced due to wear on the lenses. The RR stated they spoke with Staff J, Social Services Director (SSD), and was told they would look into what needed to be done to replace the glasses. An observation on 03/18/2025 at 10:02 AM, showed Resident 29 resting in bed. Their glasses were lying on the bedside table next to the resident's bed. Observation of the lenses of the glasses showed the protective film on each lens had deteriorated and was peeling, obstructing the clarity of the lenses. Review of a progress note dated 03/17/2025, showed Staff J had met with Resident 29's representative and informed them that Resident 29 was receiving palliative care and did not qualify for vision appointments. During an interview on 03/19/2025 at 8:41 AM, Staff J stated the family had brought concerns related to Resident 29's glasses to them on 03/17/2025. Staff J stated they had told Resident 29's RR since Resident 29 was on palliative care, they did not typically send residents out for appointments for things like that. Staff J stated palliative and hospice care (specialized care that focuses on comfort and quality of life for individuals with a terminal illness) were the same type of care. During an interview on 03/20/2025 at 2:29 PM, Staff B, Director of Nursing, stated the process for ensuring respect and dignity during toileting included assisting the resident to the restroom and ensuring privacy by closing the door to the restroom. Staff B stated they were unsure why the NAs were using the small restroom (# 104) for residents that required a mechanical lift for transfers. On the same day, during a follow-up interview at 3:20 PM, Staff B stated their expectation was for staff to close the restroom door when toileting residents. Staff B stated the process for obtaining necessary items for residents on palliative care included reviewing the need with the resident and/or their RR and proceed with obtaining the items that the resident needed. Reference: WAC 388-97-0180(1)(2)(4)(a)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 45117 Based on interview and record review, the facility failed to ensure residents retained the right to exercise self-determination regarding their dining experience for 1 of 2 residents (Resident 14) reviewed for choices. This failure placed the residents at risk for dissatisfaction in their dining experience and decreased self-worth. Findings included . Review of a policy titled, Resident Rights, last edited 10/28/2024, showed the resident had the right to and the facility must promote resident self-determination through the support of resident choice, including the right to make choices about aspects of their life that were significant to the resident. <Resident 14> Review of the medical record showed Resident 14 was admitted to the facility with diagnoses including Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), difficulty speaking, and difficulty swallowing. The 02/06/2025 comprehensive assessment showed Resident 14 was dependent on one to two staff members for activities of daily living. The assessment also showed Resident 14 was able to make their needs known. During a concurrent interview on 03/20/2025 at 11:04 AM, Resident 14's Representative stated the resident did not want to eat their meals in the dining room. Resident 14 stated they wanted to eat in their room because the dining room was too noisy. Resident 14 stated they had told staff they did not want to eat in the dining room but was told they had to because of their choking issues. During an interview on 03/20/2025 at 4:23 PM, Staff B, Director of Nursing, stated the residents had the right to choose where they have their meals, either the dining room or their own room. They stated when a resident required assistance with meals and chose to eat in their room, the facility would provide staff to assist. Staff B stated they were unsure why Resident 14's choices were not honored. Reference: WAC 388-97-0900(1)(3)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35676 Based on interview and record review, the facility failed to review and validate the Preadmission Screening and Resident Reviews ([PASARR], an assessment to ensure individuals with serious mental illness [SMI] or intellectual/developmental disabilities [ID/DD] are not inappropriately placed in nursing homes for long term care) were corrected on admission and had the required Level 2 referral sent for a positive Level 1 PASARR for 2 of 3 residents (Residents 31 and 26) reviewed for PASARR. This failure placed the residents at risk for not receiving the care and services appropriate for their needs. Findings included . Review of the Department of Social and Health Services, Dear Nursing Home Administrator Letter, guidance titled, Clarification to the Pre-Admission Screening and Resident Review (PASARR or PASRR) Level 1 Screening Process, dated 07/06/2024, showed a positive level one PASARR screen (that would then require a referral for a level two PASARR) was Any of the questions in Section 1A (1, 2, and/or 3) are marked Yes: or sufficient evidence of SMI is not available, but there is a credible suspicion that a SMI may exist; and the requirements for exempted hospital discharge do not apply . Additionally, nursing facilities will ensure residents with a positive level one PASARR screen have been evaluated by the designated state-authority through the level two PASARR process and approved for admission prior to admitting to the nursing facility. <Resident 31> Review of Resident 31's medical record showed the resident was admitted to the facility on [DATE] with diagnoses including depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), restlessness, agitation, and insomnia (trouble sleeping). Review of the quarterly comprehensive assessment, dated 01/25/2025, showed the resident's cognition was moderately impaired and required minimal assistance of one staff member for activities of daily living (ADLs). Review of Resident 31's PASARR dated 09/27/2024, showed Resident 31 had a SMI of both depression and anxiety. Review of Resident 13's medical record showed no level 2 referral had been sent for review. <Resident 26> Review of Resident 26's medical record showed the resident was admitted to the facility on [DATE] with diagnoses including depression, anxiety, and insomnia. Review of the quarterly assessment dated [DATE] showed the resident was cognitively intact and required substantial assistance of one to two staff members for ADLs. Review of Resident 26's PASARR dated 09/27/2024, showed Resident 26 had SMI's including an adjustment disorder, depression and anxiety. Review of Resident 26's medical record showed no Level 2 referral had been sent for review. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/20/2025 at 4:22 PM with Staff J, Social Services Director, they stated they had become aware of the requirement to send out a referral for a PASARR Level 2 if section 1A listed a SMI/ID diagnosis. Staff J stated they had been going through all the resident's records to assure they were correct but had not reviewed all of the resident's records yet. Reference: WAC 388-97-1975 (1)(2)(3)(4), -1915 (1)(2)(a-c)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 45117 Based on observation, interview, and record review, the facility failed to ensure a resident that experienced past trauma received care and services directed at avoiding re-traumatization and promoting healing and recovery, in accordance with professional standards of practice for 1 of 3 residents (Resident 29), reviewed for trauma informed care. This failure placed the resident at risk for unidentified trauma triggers and re-traumatization. Findings included . Review of a policy titled, Trauma Informed Care, last edited 10/28/2024, showed the facility would collaborate with the resident and/or their family and provider to develop and implement individualized care plan interventions. Additionally, the facility would identify triggers which may re-traumatize residents with a history of trauma. Those identified triggers would be added to the resident's care plan. <Resident 29> Review of the medical record showed Resident 29 was admitted to the facility with diagnoses including parkinsonism (a progressive disease that causes rigidity, tremors, and unstable posture), aphasia (a disorder that affects the ability to communicate), vision and hearing loss. The 02/13/2025 comprehensive assessment showed Resident 29 was dependent on one to two staff for activities of daily living, including eating. The assessment also showed Resident 29 had a severely impaired cognition. During an interview on 03/17/2025 at 12:59 PM, Resident 29's representative (RR) stated the resident was severely physically and mentally abused by their spouse, and their mother growing up. The RR stated Resident 29 had triggers (a stimulus, situation, or memory that causes a strong emotional or physical reaction to past trauma or negative experiences), specifically with any fast movements and/or movement towards their face. The RR stated Resident 29 needed to be fed slow because they were scared due to the trauma and their limited vision. Review of a Social Service Assessment form, completed on admission, dated 06/06/2024, showed Staff J, Social Services Director, had completed the assessment and had noted Resident 29 had a prior history of abuse. The documentation showed the resident had repeated, disturbing memories, thoughts, or images of a stressful experiences from the past that were triggered by loud noises and was jumpy. Review of the care plan dated 03/17/2025, showed no documentation related to Resident 29's history of trauma or identified triggers. During an interview on 03/19/2025 at 8:29 AM, Staff J stated the process for screening for trauma included completing the Social Service Assessment. Staff J stated if the resident had a history of trauma, they would update the care plan with identified triggers and interventions. Staff J stated they were not aware of any concerns related to a history of trauma and/or abuse for Resident 29. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/20/2025 at 2:20 PM, Staff B, Director of Nursing, stated the Social Services Director was responsible for completing the trauma screen on admission. Staff B stated the identified trauma, and triggers should have been addressed and entered onto Resident 29's care plan. Reference: WAC 388-97-1060(1)(3)(e)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 48368 Based on interview and record review, the facility failed to ensure residents were free of significant medication errors for 1 of 5 residents (Resident 2) reviewed for unnecessary medications. The failure to administer an anti-depressant medication as ordered placed the resident at risk for less than an optimal therapeutic effect and/or a potential negative health outcome. Findings included . Review of a policy titled, Medication Errors, dated 04/03/2024, showed the facility would ensure medications would be administered according to physician's orders. <Resident 2> Review of the medical record showed Resident 2 was admitted to the facility with diagnoses including major depressive disorder (a serious mental health condition characterized by persistent feelings of sadness, loss of interest, and other symptoms that interfere with daily life), and anxiety. The 12/27/2024 comprehensive assessment showed Resident 2 was dependent on one to two staff members for activities of daily living. Further review showed Resident 2 was taking an anti-depressant (type of medication used to treat clinical depression) medication and had an intact cognition during the assessment period. Review of a physician order dated 11/05/2024, showed an order for paroxetine (a brand of anti-depressant medication) to be given daily for Resident 2's diagnosis of depression and anxiety. Further review showed the medication was to be given for 90 days, with a stop date of 02/03/2025. Prior to the stop date, the Primary Care Provider (PCP) was to reassess the medication for necessity. Review of a provider visit note dated 01/28/2025, showed Resident 2's medication was reviewed by the PCP with an order to continue the anti-depressant medication daily ongoing indefinitely. Review of the February 2025 medication administration record (MAR) showed the antidepressant medication was discontinued on 02/03/2025. Additionally, the record showed an order on 02/21/2025 for the anti -depressant medication once daily to be restarted (18 days after the original order was discontinued even though the PCP gave an order to continue the anti-depressant medication on 01/28/2025). During an interview on 03/20/2025 at 1:14 PM, Staff B, Director of Nursing, stated the order for the anti-depressant medication for Resident 2 did not get continued after the original order, written for 90 days, had been discontinued. Staff B stated they did not see that anyone had caught that medication error. Staff B further stated the process for receiving orders for any medication change was to review the current order to ensure no changes needed to be made. Staff B stated the process was not followed for Resident 2, and it was just missed. During an interview on 03/20/2025 at 4:36 PM, the PCP stated they were not notified of the medication error and had discovered the error while they were doing a review of Resident 2's medications. The primary care provider further stated they would expect to be notified on any medication errors. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference: WAC 388-97-1060(3)(k)(iii)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117 Based on observation, interview, and record review, the facility failed to obtain a current hospice written agreement and develop and implement a process that ensured effective communication, collaboration, and coordination of care between the facility and hospice provider for 1 of 2 residents (Resident 14) reviewed for hospice services. This failure placed the resident at risk for not receiving necessary care and services at end-of-life. Findings included . Review of a policy titled, Hospice Services Coordination, dated 01/22/2024, showed the facility would maintain a written agreement with the hospice provider that specified the care and services to be provided and the process for hospice and nursing home communication. The facility would communicate with hospice and identify, communicate, follow and document all interventions put into place by hospice and the facility. <Resident 14> Review of the medical record showed Resident 14 was admitted to the facility with diagnoses including Parkinson ' s disease without dyskinesia (a progressive disease that destroys memory and other important mental functions, and causes tremors, rigidity, and slowness of movement, but without involuntary movements), and heart failure. The 02/06/2025 comprehensive assessment showed Resident 14 was dependent on one to two staff for activities of daily living and was able to make their needs known. Review of the written hospice agreement titled Nursing Facilities Services Agreement, dated 08/01/2019, showed the agreement would be reviewed no less than annually. There was no documentation that the document was reviewed since the initial agreement dated 08/01/2019 and was not signed by an authorized representative of the facility. Review of a document titled Medicare Election Form- [NAME], dated 03/12/2025 showed the Resident 14 ' s Representative enrolled Resident 14 into Hospice services with a Start of Care Date of 03/12/2025. Review of Resident 14 ' s care plan, showed no focus area, goals, or interventions related to hospice services until 03/18/2025. During an interview on 03/17/2025 at 10:13 AM, Collateral Contact 1 (CC1), Hospice Registered Nurse, stated Resident 14 was brand new to hospice services and they were performing their initial assessment. They stated there should be a care plan in place for Resident 14. CC1 stated they gave a verbal report to the facility nursing staff before and after each visit. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/19/2025 at 1:29 PM, Staff M, Licensed Practical Nurse, stated there was a binder for staff to leave notes for Hospice, but generally they would do a phone call or fax with the Hospice staff if there was a need. They stated Resident 14 was new to Hospice and did not have anything in the binder yet and the binder was mostly used for the nursing assistants to communicate things like showers. Review of the Hospice Communication Log showed no entries for Resident 14. During an interview on 03/20/2025 at 2:49 PM, Staff B, Director of Nursing, stated the process for ensuring the facility had a current agreement was the responsibility of the Administrator and the facility was working on an updated agreement. They stated the process for communication, collaboration, and coordination of care between the facility and the Hospice provider included the Hospice providers receiving the referral for services, meeting with the resident and/or their representative, and formulating care plan. They stated once the services were initiated, the Hospice staff would inform the nursing staff when they entered the building to perform services, sign in/out of the Hospice logbook, and report findings of their visit to both the nurse and the family. Staff B stated they expected facility nursing staff to document visits/conversations with the Hospice staff in the nursing progress notes. Reference: WAC 388-97-1060(1)