

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 06/04/2026
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.			
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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents consistently received restorative therapy services (movement of joints to maintain range of motion) to maintain range of motion (ROM) for 3 of 12 residents (Residents 24, 1 and 6) reviewed for ROM/mobility. This failure placed residents at risk of decreased joint motion, progressive contractures and a diminished quality of life. Findings include . Resident 24 Review of the medical record showed the resident admitted to the facility with diagnoses including stroke (when blood stops flowing to part of your brain), dementia (a decline in mental abilities severe enough to interfere with daily life) and a left sided hemiplegia (a neurological condition causing severe or complete paralysis on one side of the body). The 03/01/2026 comprehensive assessment showed Resident 24's cognition was severely impaired and required the assistance of one staff member with activities of daily living and had a contracture to the left hand. Review of Resident 24's care plan dated 01/23/2026 showed the resident was scheduled to receive a restorative nursing program for passive range of motion (PROM- moving a person's joints for them when they cannot move then on their own) to their upper extremities. The care plan specified that the resident was to receive left hand upper extremity exercises that directed staff to place objects in a tub, fill it with water, instruct the resident to retrieve the objects from the water, and thoroughly dry the resident's hands upon completion of the activity with a goal to complete the program three of seven days a week. Review of the resident's electronic medical record within the tasks section (the facility's digital flow sheet used by staff to document the actual delivery of scheduled care) for May 2026 showed the scheduled restorative program was documented as completed on only three out of 31 days (05/04/2026 documented as completed, 05/05/2026 documented as not applicable and 05/06/2026 documented as a resident refusal). The electronic record contained no documentation, shift entries, or clinical justifications for the remaining 28 days of omissions. (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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and concurrent interview on 05/31/2026 at 1:42 PM, showed Resident 24 sitting in their wheelchair with their left arm laying flaccid in their lap. Resident 24's left hand had severe contractures, tightly closed in a fist with the thumb positioned over the fingers, and a foul odor was emitting from the hand. Resident 24 stated they could not open their hand, stating it would break. Resident 24 further stated they did not receive any exercises for that hand. During an observation of hand hygiene on 06/04/2026 at 9:57 AM, Staff H, Nursing Assistant (NA), performed hand hygiene on Resident 24's contracted left hand using a warm washcloth. Immediately following this intervention, the washcloth was observed covered in a brown substance extracted from the resident's palm. Staff H stated the palm was very dirty and red. Observation of the resident's palm directly under the thumb showed a red area emitting a strong, foul odor. During an interview on 06/02/2026 at 2:23 PM, Staff P, Restorative Assistant, stated Resident 24 was on an active restorative nursing program for ROM but services were disrupted due to facility staffing difficulties. Staff P stated they were consistently pulled to the floor the entire month of May 2026, and no restorative programs were completed except for those 3 days that were charted for Resident 24. Staff P further stated they did not have a nurse providing oversight and administrative monitoring. Staff P further stated, we have not been having any meetings or anything for restorative in a long time. During an interview on 06/03/2026 at 4:38 PM Staff A, Administrator, stated they did not have any therapy in the building during most of May 2026 and were aware of the restorative issues. Staff A stated that the facility failed to maintain the required restorative services during this time and they were currently working on fixing the issue.' Review of the facility's policy, titled, Restorative Program, dated 10/24/2024, showed Residents, as identified during the comprehensive assessment process, will receive services from restorative aides when they are assessed to have a need for restorative nursing services. These services may include; passive or active range of motion. Resident 1 Review of Resident 1's medical record showed the resident was admitted to the facility on [DATE] with diagnoses to include quadriplegia (partial or total paralysis of all four extremities and torso), depression (a serious mood disorder characterized by persistent sadness and loss of interest in daily activities) and need for assistance with personal care. During an observation and concurrent interview on 05/31/2026 at 2:01 PM, Resident 1 had limited movement to their left hand. Resident 1 stated that they were not receiving any therapy right at that time. (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 1's daily Kardex (a task sheet with a resident's daily care needs, used for easy reference by the nursing staff) showed Resident 1 had an active range of motion (AROM) and a passive range of motion (PROM) program for their upper and lower extremities. During an observation and concurrent interview on 06/02/2026 at 4:08 PM, Resident 1 was observed with contracted ring and pinky fingers on their left hand. The resident stated they did not wear a brace on their hand at night. Resident 1 stated, I do need one to hold these fingers straight . If they had something that would hold my fingers straight, I'd wear it. Resident 6 Resident 6 was admitted to the facility on [DATE] with diagnoses to include persistent vegetative state (a condition where a person with severe brain damage appears awake but has no conscious awareness of themselves or their surroundings) and contractures (the permanent tightening and shortening of muscles, tendons, ligaments, or skin) of both arms and both hands. The comprehensive assessment dated [DATE] showed the resident's cognition was severely impaired and was dependent on staff for all mobility and cares. Review of Resident 6's daily Kardex showed Resident 6 was to have a PROM program for their upper and lower extremities daily. In an observation and concurrent interview on 06/01/2026 at 10:10 AM, Resident 6 was observed sitting in a tilt-in-space wheelchair with visible bilateral upper arm contractures. The Resident Representative (RR) stated the facility's therapy was not enough. The RR stated, If they don't get therapy, they will get really stiff. Therapy needs to be done every day .so, I come in to do their range of motion every day. In an interview on 06/02/2026 at 11:00 AM, Staff P, Restorative Assistant, stated that during the month of May 2026, residents did not receive a consistent restorative program. Staff P stated that Resident 1 and Resident 6 were on active programs, but because restorative aides were routinely pulled to work as floor Nursing Assistant (NA), the restorative programs could not be completed. During an interview on 06/03/2026 at 9:33 AM, Staff M, NA, stated that floor NAs did not perform restorative programs because the facility has designated restorative aides. Staff M verified that the restorative aides work the floor a lot due to staffing needs and added that the facility had been without therapy services for a few weeks. Reference: WAC 388-97-1060 (3)(d)		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and record review, the facility failed to provide the Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (SNF ABN) for 1 of 3 residents (Resident 48) reviewed for Beneficiary Notices. This failure placed residents and/or their representatives at risk of not having adequate information to make financial decisions related to the residents' stay within the facility. Findings included . Review of a Notice of Medicare Non-Coverage, dated 02/08/2026, showed Resident 48 had not been provided with a SNF ABN prior to their discharge from the facility. In an interview on 06/01/2026 at 2:05 PM, Staff K, Business Office Manager (BOM), stated they were responsible for notifying residents of changes in their Medicare coverage. Staff K stated they had not provided Resident 48 with the SNF ABN form, they were unaware they were to provide the form. In an interview on 06/01/2026 at 2:18 PM, Staff A acknowledged that Resident 48 had not been provided with the SNF ABN form and stated they should have been. Staff A stated they had educated the BOM of the process. Reference (WAC) 388-97-0300 (4) (a-c)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview, record review, and observation, the facility failed to ensure information regarding the grievance process was readily available for residents or resident representatives [RR]) and failed to ensure residents were aware of their right to file grievances anonymously. These concerns were voiced in Resident Council (a formal meeting for facility residents to communicate preferences and concerns) for 3 of 5 residents (Resident 26, 39, and 75) reviewed for grievances. This failure placed residents at risk for overall dissatisfaction with their care and unresolved concerns. Findings included . Review of the facility policy, titled, Resident and Family Grievances, revised date 10/28/2019 showed how to file a grievance or complaint would be available to residents. During an observation on 06/02/2026 at 9:28 AM, throughout the facility there were no physical grievance forms available for resident or RR access. In an interview on 06/02/2026 at 10:19 AM, Residents 26, 39, and 75 stated they did not know where grievance forms were located were unaware, they could submit forms anonymously, and that they believed staff members had to fill out the forms on their behalf. In an interview on 06/03/2026 at 4:21 PM, Staff L, Activities Director, stated grievance forms were kept on the wall near the nursing assistant charting area and the Director of Nursing Services office. They acknowledged that if residents did not know what the forms looked like or where they were located, the facility needed to re-educate them and improve their process. In an interview on 06/03/2026 at 4:42 PM, Staff A, Administrator, acknowledged a gap in resident awareness regarding the grievance process. Staff A confirmed that some residents could be unfamiliar with their right to file anonymously and where to locate physical grievance forms. Reference: WAC 388-97-0460		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents, dependent on staff, received necessary care and services. The facility failed to provide consistent, oral care and personal grooming (nail care) for 2 of 2 residents (Resident 1 and 24) reviewed for Activities of Daily Living (ADLs). This failure placed residents at risk for impaired skin integrity, oral infections, unmet care needs and embarrassment. Findings include. Review of the facility policy titled, Activities of Daily living (ADLs) dated 10/24/2024, showed based on the resident's comprehensive assessment and consistent with the resident's needs, care and services would be provided that included grooming and oral care. Resident 1 Review of the resident record showed the resident admitted to the facility on [DATE] with diagnoses to include quadriplegia (the partial or total paralysis of all four extremities (both arms and both legs) and the torso) and need assistance with personal care. The comprehensive assessment dated [DATE] showed the resident was dependent on staff for ADLs. Review of Resident 1's undated Kardex directed nursing assistants to provide mouth care and personal hygiene. In an interview on 05/31/2026 at 2:11 PM, Resident 1 stated they were unable to access supplies independently and had not brushed their teeth that day. Resident 1 stated staff do not offer a setup to brush their teeth. During an observation 06/01/2026 at 8:08 AM, Resident 1 laying in their bed with the head of the bed elevated for their breakfast, with disheveled, oily hair. The resident's toothbrush was observed dry and stored in a crayon caddy on the bedside table. In an interview on 06/01/2026 at 8:53 AM, Staff M, Nursing Assistant (NA), stated Resident 1 had been cooperative with care but verified they had not offered oral care that morning. During an observation on 06/01/2026 at 4:10 PM, Resident 1 with brown teeth and a thick, white film along the gumline. The resident stated that staff did not offer oral care, stating, They don't offer supplies and I can't get it myself. During an observation and concurrent interview on 06/02/2026 at 9:17 AM, Resident 1's toothbrush was observed dry with visible dirt and fuzz embedded in the bristles. The resident stated the staff had not offered oral care that morning. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 06/03/2026 at 11:06 AM, Staff N, NA and Staff J, NA were observed providing a bed bath for Resident 1. The resident's toothbrush remained dry with dark specks of dirt and fuzz. The resident's teeth exhibited a brown color and a white film along the gumline. The CNAs completed the bed bath and changed the resident's gown and bed linen but failed to offer or provide oral care. In an interview on 06/03/2026 at 10:20 AM, Staff E, Resident Care Manager (RCM) and Staff G, RCM acknowledged that while the resident occasionally refuses other care (such as therapies or braces), facility staff had completely failed to offer oral care to the resident. Resident 24 Review of the medical record showed the resident admitted to the facility with diagnoses including stroke (when blood stops flowing to part of your brain), dementia (a decline in mental abilities severe enough to interfere with daily life). The 03/01/2026 comprehensive assessment showed Resident 24's cognition was severely impaired and required the assistance of one staff member with personal hygiene. Review of Resident 24's care plan, dated 04/13/2022, showed that the resident had an activity of daily living self-care performance deficit and required assistance of one staff member with all personal hygiene. During an observation and concurrent interview on 05/31/2026 at 1:42 PM, Resident 24 was observed sitting in their wheelchair. Resident 24's left hand presented with severe contractures and emitted a very foul odor. Resident 24's left thumb was tightly positioned on top of their first finger. Resident 24 stated that their left hand cannot open, it will break and stated no one opens that hand. Further observation showed Resident 24's fingernails were long and jagged, with chipped nail polish and a brown substance accumulated underneath the nails. During an observation on 06/01/2026 at 2:16 PM showed Resident 24 had long, jagged fingernails with old, chipped green nail polish and a brown substance remaining underneath the nails. Resident 24's left hand fingernails were observed digging into their palm, and a strong, foul odor was emitting from the hand. During an observation on 06/02/2026 at 2:15 PM, Resident 24 was ambulating in the hallway. Observation of both hands revealed the identical unkempt appearance from previous days. Resident 24's fingernails remained long, jagged, covered in old, chipped green nail polish, with a brown substance visible underneath the nails. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and concurrent interview on 06/04/2026 at 9:57 AM, Staff H, Nursing Assistant (NA), stated they had tried to cut Residents 24's nails and they had pulled away and they had not attempted since. Staff H then performed hand hygiene on Resident 24's contracted left hand using a warm washcloth. Immediately following this, the washcloth was observed covered in a brown substance extracted from the resident's palm. Staff H stated the palm was very dirty and red. Observation of the resident's palm directly under the thumb showed a red area emitting a strong, foul odor. During an interview on 06/03/2026 at 4:39 PM, Staff A, Administrator stated the NA's were responsible for nail care which was to be done daily with care and as needed. Staff A stated they were aware of the nail care issue and that it was very disappointing. Staff A further stated more training needed to be done with the NA's. Reference: WAC 388-97-1060 (2)(c)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on interview and record review, the facility failed to ensure that specific facility primary provider dialysis (a medical treatment that acts as an artificial kidney, it filters waste, toxins, and extra fluid out of the blood) monitoring orders were implemented and followed for 1 of 1 residents (Resident 18) reviewed for dialysis care. This failure placed the residents at risk for fluid overload, electrolyte imbalances, cardiovascular instability, and missed identification of life-threatening post-dialysis complications. Findings included. Review of the medical record showed the resident admitted to the facility with diagnoses end stage renal disease (when your kidneys have lost their function, leaving them unable to adequately filter waste and excess fluid from the blood to support daily life). The 03/01/2026 comprehensive assessment showed Resident 18's cognition was intact and required the assistance of one- two staff members with activities of daily living and was receiving dialysis treatments. Record review of a provider encounter dated 05/11/2026, showed orders as follows: Obtain daily weights and notify the provider for a weight gain of 2 pounds (lbs.) in 24 hours, or 5 lbs. in 7 days. If a weight gain of 2 lbs. in 24 hours is accompanied by dyspnea (shortness of breath) or edema (swelling), obtain a STAT (immediate) Basic Metabolic Panel (BMP-a blood test that measures your body's chemistry) and arrange an urgent dialysis adjustment. Monitor blood pressure (BP) each shift. Hold carvedilol (a medication used to treat high BP and heart failure) if systolic blood pressure (the top number of blood pressure reading) is less than 95, or if the heart rate is less than 55 beats per minute. Limit fluid intake to 1.5 liters (L) per day. Record review of Resident 18's physician orders and Medication/Treatment Administration Records (MAR/TAR) for May 2026 showed that none of the provider monitoring orders had been transcribed or implemented by the facility. Review of Resident 18's weight records from 05/13/2026 to 05/18/2026 showed a 13-lb. weight gain within five days. Furthermore, a review of weight records from 05/29/2026 to 06/01/2026 showed a 25.5-lb. weight gain within three days. A review of the medical record showed no evidence that the primary provider was notified of either of these significant weight gains, as required by the 05/11/2026 provider orders. Review of Resident 18's active dietary orders and kitchen diet slips for May 2026 showed no evidence that the ordered 1.5-liter per day fluid restriction had been implemented or communicated to the dietary staff. During observations on the following dates and times, Resident 18 was observed with unmonitored fluids at their bedside: On 06/02/2026 at 3:59 PM: A 32-ounce water cup was observed on the resident's bedside table, filled with approximately 300 cubic centimeters (cc) of water. An additional cup containing approximately 180 cc of juice was also sitting on the bedside table. On 06/03/2026 at 10:19 AM: The resident was observed with a 32-ounce water cup at their bedside containing approximately 600 cc of fluid. During an interview on 06/01/2026 at 4:17 PM, Resident 18 stated the facility did not weigh them consistently, stating, Maybe twice since I have been here. The resident further stated, I have been feeling a little more short of breath these last few days and some swelling in my hands and leg, but I have not told anyone because I'm just used to it, I guess, when I get too much fluid. During an interview on 06/02/2026 at 4:15 PM, Staff I, Licensed Practical Nurse, stated that if a resident was on a fluid restriction, it would appear on the MAR, and Resident 18 did not have a restriction listed on the MAR. Staff I further stated they were not aware of the resident's recent increase in shortness of breath or edema. Additionally, Staff I stated that the facility did not have a policy to weigh residents daily, nor did they have specific daily weight orders for dialysis patients; it was their understanding that dialysis patients were only to be weighed at the dialysis clinic. During an interview on 06/03/2026 at 4:26 PM, Staff A, Administrator, stated that the expectation for inputting provider visit orders was for the resident case (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	managers (RCMs) to review the providers visits to ensure all orders were completed and placed in the resident's electronic record. Staff A stated they had no idea this was happening; otherwise, they would have had a check system in place. Staff A further stated that there was a failure in the process. During an interview on 06/03/2026 at 4:38 PM, Staff B, Director of Nursing Services, stated that for the fluid restriction, the dietician and the provider did not pass the orders on, and that was where the process broke down. Staff B stated that the process was for the RCMs to read the provider's dictation and placed the orders into the system. Reference: WAC 388-97-1900 (1)		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interview, the facility failed to provide a safe and sanitary (relating to the conditions that affect hygiene and health) environment for 1 of 1 Laundry room, reviewed for a functional environment. This failure placed residents and staff at an increased risk of cross-contamination (the harmful spread of diseases). Findings included. During an environmental tour of the facility's laundry room on 06/03/2026 at 12:00 PM, showed: An active water leak originated from the commercial washing machine. This ongoing leak resulted in a significant accumulation of standing, pooling water directly behind and underneath the washing machine unit. The floor surface directly beneath and surrounding the commercial washing machines and chemical dispensing units showed extensive, visible water damage, pitting, and structural deterioration. The floor area beneath the liquid laundry chemical drums and intake lines showed significant discoloration and physical pitting. The flooring was unable to be properly cleaned or sanitized. Observation of the laundry room ceiling showed water damage. The affected ceiling area showed paint blistering and bubbling, with sections of the paint completely failing and peeled away, leaving the underlying drywall fully exposed. The wall surface located to the left side of the washing machine showed water damage and dark staining. Multiple areas of bubbling, peeling paint were observed, along with physical holes in the wall structure that left the interior wall components exposed, the surface was unable to be properly cleaned or sanitized. The wall surface located behind the washing machines, positioned to the right side of the window, showed a large area of water damage and structural deterioration. This affected section of the wall measured approximately 2 feet (ft- a unit of measure) by 1 1/2 ft in size. Further observation of the same wall, located to the left side of the window, showed an additional area of water damage and structural deterioration. This affected section measured approximately 3 ft by 9 inches (in- a unit of measure) in size, leaving the wall material exposed and uncleanable. Observation of the laundry room hopper showed extensive water damage to the wall directly behind the unit, rust and metal were visible through the broken drywall. The wall trim surrounding the hopper was warped and actively pulling away from the wall structure, creating surfaces that were not cleanable. Multiple areas of heavily chipped peeling paint were observed directly in front of and to the left of the hopper unit, leaving the underlying drywall fully exposed to moisture and unable to be properly cleaned or sanitized. During an interview and concurrent observation on 06/03/2026 at 12:20 PM, Staff A, Administrator, stated the facility process required the maintenance department to perform routine rounds, and all facility staff were expected to use the TELS system (an electronic communication system designed for maintenance requests) to report any environmental issues that needed to be addressed. Staff A reviewed the laundry room conditions and stated that the damage was way worse than the last time they were in the room. Staff A further stated they would expect the laundry supervisor to have reported the damage to maintenance via the electronic system and acknowledged that the facility's process was not followed. During an interview and concurrent observation on 06/03/2026 at 12:34 PM, Staff F, Maintenance Director, stated they perform environmental rounds daily but had not been in the laundry room frequently and were not aware of any of the damage on or by the windows, hopper, ceilings or floors. Staff F stated they were aware of the leak from the washing machine and were waiting on parts that were about six to eight weeks out. Staff F stated all staff communicated any repair needed verbally and utilized the TELS system. Staff F acknowledged the deficient environmental conditions. Reference: WAC 388-97-3220 (1)		