STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505475	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wesley Homes Des Moines Health Center	826 South 218th Street Des Moines, WA 98198

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure resident concerns were dealt with timely, verbal grievances were identified as such, resident rights were promoted periodically as required, and residents were provided the opportunity to make a grievance anonymously for 1 of 1 Resident Council groups reviewed. These failures placed residents at risk for unmet needs, frustration, untimely resolution of grievances, and a diminished quality of life.Findings included .<Facility Policy>According to the facility's [DATE] Resident Council Meetings policy, the Activity Director would facilitate Resident Council Meetings. The policy showed the facility would act upon concerns and recommendations of the Council . According to the facility's [DATE] Resident and Family Grievances policy, a resident could make an anonymous grievance. The policy showed notices of residents' rights regarding grievances [would] be posted in prominent locations throughout thefacility. The policy showed all staff involved in the grievance process would make prompt efforts to resolve the grievance and return the grievance form to the Grievance Official . This included both acknowledgment of the complaint/grievance and actively working toward a resolution of that complaint/grievance.Review of the facility's monthly Resident Council meeting minutes from [DATE] through [DATE] showed the following: - In the [DATE] meeting Resident 13 stated they felt like a prisoner in the facility. In the [DATE] meeting Resident 13 stated they felt a serious lack of freedom as a resident of the facility and wanted more access to the rest of the building. In the [DATE] meeting Resident 13 stated they continued to feel a serious lack of freedom and wanted more access to the rest of the building. - In the [DATE] meeting Resident 75 expressed frustration their room was not tidied at a reasonable time which embarrassed them when they had company. Resident 75 brought the same concern up a second time during the [DATE] meeting, stating their bed was not made until the afternoon, nor their room tidied before they received visitors. In the [DATE] meeting Resident 75 weekend staff did not make their bed up until after dinner.-None of the six months of Resident Council meeting minutes reviewed indicated there was any discussion of residents' rights while living at a nursing home. Review of the facility's [DATE] Grievance Log showed facility staff did not log Resident 75's housekeeping concern from Resident Council that month. The [DATE] Grievance Log did not include an entry for Resident13's concern with a lack of freedom or Resident 75's housekeeping concern from Resident Council that month. The [DATE] Grievance Log did not include Resident13's concern with a lack of freedom from Resident Council that month. The [DATE] Grievance Log did not address Resident 75's concern related to their bed not being made up until after dinner In a meeting regular attendees of the Resident Council on [DATE] at 10:44 AM, all the attendees, including Resident 13 and Resident 75, stated they were unclear on how to file a grievance. None of the four residents recalled any discussion of residents' rights during Resident Council meetings. None of the residents knew where information regarding the State's Long-Term Care Ombuds office was posted in the facility. In an interview on [DATE] at 12:02 PM Resident 13 stated after repeatedly expressing their sense of a lack of freedom in Resident Council Meetings, facility staff eventually explained the reason for the restrictions was their safety, but the concern was not addressed in a timely manner. Observation on [DATE] at 12:10 PM showed no signs posted (continued on next page)

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

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	discussing residents' right to file a grievance, no Grievance forms available for residents to complete without requesting a form, and no box or other receptacle where residents could leave a completed Grievance form without staff identifying who completed the form. In an interview on [DATE] 8:39 AM, Staff D (Activity Assistant) stated they started working with the facility's activity department in [DATE]. Staff D stated they previously worked in the restaurant industry. Staff D stated their training on hire was sparse but they were shown how to complete a Grievance Form. Staff D stated when concerns came up in Resident Council, they sent them to the Director of Nursing Services or Staff A (Health Services Administrator). Staff D stated they did not make time at Resident Council meetings to discuss residents' rights. In an interview on [DATE] at 8:53 AM Staff A stated grievance forms were available at the nurse station. Staff A asked the nurse inside the nurse station (a small room with one door, with windows where staff could observe the floor while charting) are inside the nurse station. The nurse passed Staff A grievance form from a paper organizer at the furthest end of the nurse station from the door. Staff A stated residents were not supposed to enter the nurse station. Staff A stated residents had the right to file a grievance they were unsure how a resident could file an anonymous grievance if they needed to ask for a form and there was no place to leave it anonymously. REFERENCE: WAC 388-97-0920(1)-(6).

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities Based on observation, interview, and record review the facility failed to ensure Level 2 Pre-admission Screening and Resident Review (PASRR) determinations (a process to determine whether mental health services were required after a Level 1 PASRR screening identified the need for a Level 2 review) were obtained for 3 (Residents 3, 9, & 63) of 5 residents whose PASRRs were reviewed. This failure placed residents at risk for not receiving necessary mental health care and services. Findings included . <Facility Policy>Review of the facility's revised 02/11/2026 Resident Assessment-Coordination with PASRR program showed the facility must screen residents using the State's Level I screening process and refer any resident who had a mental disorder, intellectual disability, or related condition to the appropriate state designated authority for a Level 2 PASRR evaluation and determination. The Level 2 resident review must be completed within 40 calendar days of admission. The Social Services Director would be responsible for keeping track of each resident's PASRR screening status and referrals to the appropriate authority.<Resident 3> According to the 12/26/2025 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 3 had Post-Traumatic Stress Disorder (PTSD), and a mood disorder. The MDS showed Resident 3 received an antidepressant medication. Review of Resident 3's 03/12/2025 Level 1 PASRR showed the resident was reassessed for mental health conditions due to a change in their medical diagnoses to include anxiety. The corrected Level I PASRR showed Resident 3 had a mental disorder of a mood disorder and anxiety and should be referred for a Level 2 evaluation. Review of Resident 3's medical records, Care Plan (CP) and progress notes showed no indication that a Level 2 PASRR determination was obtained until 1/26/2026, ten months after the initial Level 2 referral was indicated. In an interview on 02/12/2026 at 10:30 AM, Staff C (Director of Social Services) stated if a resident was identified to have serious mental illness indicators (SMI), the facility would submit a Level II PASSR evaluation and verify and document any communication with the evaluators to obtain an assessment. Staff C stated there was a delay in processing Level 2 PASRR evaluations and there should be emails discussing the pending status but was unable to provide copies of emails from March 2025 through October 2025. <Resident 9> According to the 12/19/2025 Quarterly MDS, Resident 9 had diagnoses including PTSD, a mood disorder, a mental health condition with symptoms such hallucinations, delusions, and disorganized speech affecting their mood, and dementia. The MDS showed Resident 9 took an antipsychotic medication. Record review showed the most recent PASRR Level 1 screening for Resident 9 was completed on 08/21/2025 and indicated Resident 9 had SMI indicators of PTSD, a mood disorder, and the other mental health condition identified on the MDS. This Level 1 screening showed Resident 9 had dementia and required a Level 2 referral. No corresponding Level 2 evaluation or invalidation was found in Resident 9's record. In an interview on 02/12/2026 at 10:19 AM, Staff C stated they sent out the 08/21/2025 Level 1 (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	screening for a Level 2 determination and stated they followed up to inquire on the status on 11/14/2025 but did not document the conversation. Staff C stated they were familiar with the requirement for follow-up when a facility was waiting for a decision regarding a Level 2 evaluation. Staff C stated Resident 9 was on their assistant's case load and they would follow up with the assistant to determine if they had further documentation to demonstrate follow-up for the Level 2 referral. No further documentation was provided demonstrating follow-up for Resident 9. <Resident 63> According to the 01/16/2026 Quarterly MDS, Resident 63 had diagnoses including dementia and psychosis. The MDS showed Resident 63 took an antipsychotic medication. Review of Resident 63's most recent Level 1 PASRR dated 10/29/2024 showed the resident was identified with SMI of a psychotic disorder and delusional disorder and had a dementia diagnosis. The Level 1 PASRR showed a Level 2 evaluation referral was required. No corresponding Level 2 PASRR evaluation or invalidation was found in Resident 63's chart. In an interview on 02/12/2026 at 10:19 AM, Staff C stated Resident 63 was on their assistant's case load who was unavailable and could not immediately demonstrate what efforts the facility made to follow up with the Level 2 referral. Staff C stated they would reach out to their assistant and provide whatever additional information they could to demonstrate the facility followed up monthly. Staff C later sent information showing the facility confirmed the Level 2 referral was received by the PASRR agency on 10/03/2025, and evidence of an email sent by their assistant on 11/06/2025 providing clinical documentation to the evaluator's office. There was nothing to demonstrate follow up after 11/06/2025. REFERENCE: WAC 388-97-1915(1)(2)(a)-(c).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure medications were stored and labeled in accordance with currently accepted professional standards of practice. The facility failed to: (1) label medications properly and dispose of expired medications and medical supplies timely for 1 of 2 medication carts (300 West) and 2 of 2 storage rooms (300 East and 300 West) reviewed; and (2) monitor medication refrigerator temperatures for 2 of 2 storage rooms (300 East and 300 West) reviewed. These failures placed residents at risk of receiving compromised medications with reduced or no potency, receiving care with degraded supplies, and experiencing an overall decline in quality of life.Findings included .<Facility Policy>According to the facility's 11/10/2022 Medication Storage policy, the facility would remove and dispose of expired medications and equipment promptly, and medication refrigerators would be monitored per the facility's procedure for ensuring temperatures remained within the required range.<300 East Medication Storage> <Medication Refrigerator> Review of the facility's Temperature Log for Refrigerator form, located in the 300 East medication room, showed the staff were to monitor the temperature during AM and PM shifts each day and act if the temperature was below 36 degrees Fahrenheit (F) or above 46F. Review of the February 2026 refrigerator temperature log from 02/01/2026 until 02/09/2026 showed 5 of 17 temperatures were not monitored (one AM and four PM shifts). Observation on 02/09/2026 at 10:32 AM with Staff J (Registered Nurse - RN, Team Leader) showed there were temperature-sensitive medications located inside the 300 East medication refrigerator including insulin (a medication to help lower blood sugar), antianxiety medication, and testing supplies. Staff J stated it was important to monitor the refrigerator temperature to ensure medications remained effective. Staff J reviewed the February 2026 temperature logs and stated staff should have monitored the refrigerator temperature consistently as expected, but they did not. Observation at that time showed a box containing an open vial of tuberculosis (an infectious, airborne disease affecting the lungs) testing solution was not dated to indicate when the bottle was opened or when it needed to be discarded. Staff J stated the vial should be discarded. <Expired Medications and Medical Equipment> Observation on 02/09/2026 at 10:32 AM with Staff J in the 300 East medication storage room showed expired medication and medical supplies ranging from 2019 to 2025, including 22 insulin syringes, 10 blood collection syringes, 37 blood collection tubes, 14 anticlotting test kits, 10 specimen collection kits, 1 urine drainage bag, 1 oxygen tubing set and 1 full bottle of Vitamin D tablets. At that time, Staff J confirmed all the expiration dates and stated the items should have been discarded but were not. In an interview on 02/12/2026 at 10:15 AM, Staff B (Director of Nursing Services) stated it was their expectation all medications were labeled with the date they were opened. Staff B stated it was their expectation all medications and medical supplies were discarded prior to the expiration date on the packaging. <300 [NAME] Medication Storage> (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Medication Refrigerator> Observation of the medication refrigerator temperature log on 02/09/2026 at 9:33 AM showed no temperature readings documented on 02/01/2026 and 02/08/2026. <Medication Cart> Observation on 02/09/2026 at 9:52 AM, showed the medication cart had one bottle of a magnesium supplement with an expiration date of December 2025, one bottle of a pain reliever with a strength of 200 milligram with an expiration date of January 2026 and one bottle of a non-steroidal, anti-inflammatory drug with an expiration date of January 2026. In an interview on 02/09/2026 at 9:52 AM, Staff H (RN, Team Leader) stated expired medications should not be on the cart, available for administration. Staff H stated all nurses were responsible for checking their medication carts for expired medications, but these expired medications should have been discarded but were not. In an interview 02/09/2026 at 12:47 PM, Staff F (RN, Resident Care Manager) stated medications should be stored at the correct temperatures in the medication refrigerator and staff should check the temperature daily but did not. Staff F stated, for residents' safety, expired medications should not be on the cart to prevent errors and to make sure medications were safe. REFERENCE: WAC 388-97-1300(1)(b)(ii)(2).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review the facility failed to: ensure staff posted and followed Transmission Based Precautions (TBP - a set of infection control practices used to prevent the spread of infectious agents, in addition to standard precautions) for 1 of 4 residents (Resident 40) reviewed for TBP; ensure staff used appropriate Personal Protective Equipment (PPE - disposable barriers such as gloves, eyewear, and gowns used to prevent exposure to infectious materials) for 1 of 4 residents (Resident 44) reviewed for Enhanced Barrier Precautions (EBP - an infection control intervention designed to reduce the transmission of multidrug-resistant organisms); and ensure staff used appropriate Hand Hygiene (HH) during meal service. These failures placed residents and staff at risk for exposure to and development of communicable infectious diseases.Findings included .<Facility Policy>Review of the facility's revised 07/26/2024 Transmission-Based Isolation Precautions policy showed the facility would implement TBP to prevent the spread of pathogens (organisms that enter the body and cause disease) based on the way the pathogens' spread (airborne, contact or droplet) to prevent or control infections.Review of the facility's revised 07/26/2024 Management of C. Difficile Infection policy showed the facility would implement facility-wide strategies to prevent the spread of Clostridioides difficile (C. diff - a type of bacteria found in stool that causes diarrhea and swelling of the large intestine). Staff were to implement TBP's when C. diff infection was suspected and until test results were confirmed but no less than 48 hours after diarrhea had resolved. The facility policy showed staff were expected to wear gloves and a gown upon entry into the resident's room and perform all hand hygiene with soap and water. Staff would use disposable equipment whenever possible and disinfect reusable items with a sporicidal disinfectant (chemical to kill bacteria with a tough protective shell).Review of the facility's revised 01/19/2025 Enhanced Barrier Precautions policy showed the facility would implement EBP's to prevent the spread of multidrug-resistant organisms for residents with wounds such as chronic venous stasis ulcers. Staff were to perform hand hygiene and wear gloves and a gown when performing high-contact care activities including wound care with any skin openings requiring a dressing.<TBP/C. Diff> <Resident 40> According to a 01/29/2026 admission Minimum Data Set (MDS - an assessment tool), Resident 40 had multiple medically complex diagnoses including a C. diff infection and was at risk for malnutrition and dehydration. Review of Resident 40's February Medication Administration Record showed a 01/31/2026 physician order to start isolation precautions for C. diff and an order for vancomycin (an antibiotic medication to treat C. diff) which ended with a final dose on 02/03/2026 at 9:00 PM. Review of a 02/05/2024 at 9:55 AM nursing progress note showed Resident 40 had completed antibiotic treatment for C. diff and continued to experience loose stools. The note showed staff received a physician's order to send a stool sample to the laboratory to recheck Resident 40 for C. diff. Review of Resident 40's Order Summary Report showed a 02/05/2026 physician's order instructing staff to collect and submit a stool sample to re-check for C. diff. Observation on 02/05/2026 at 10:14 AM showed Resident 40's room displayed a Contact Precautions (infection control measures used in healthcare settings to prevent the spread of germs transmitted by direct or indirect contact with a resident or their environment) sign outside the door instructing (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	everyone to clean their hands before entering and upon leaving and showing an image of hand sanitizer gel. The sign directed staff to wear gloves and a gown before entering and remove them before exiting, and required the use of dedicated or disposable equipment, with all reusable items to be disinfected. In an interview on 02/05/2026 at 10:16 AM, Staff N (Registered Nurse - RN, Team Leader) stated Resident 40 finished the prescribed antibiotic treatment for C. diff but still had loose stools. Staff N stated a stool sample was sent to the laboratory and the facility procedure was to continue precautions until test results were confirmed. Observation on 02/05/2026 at 12:22 PM showed Staff I (Certified Nursing Assistant) handed a meal tray to a nursing student and pointed toward Resident 40's room. The student entered Resident 40's room without performing hand hygiene or putting on a gown or gloves, placed the meal tray containing reusable dishware on the bedside table, adjusted the head of the resident's bed, and removed the reusable tray lid. The student left Resident 40's room without performing hand hygiene, placed the lid on top of other lids on the meal cart, and entered the 300 East nursing station. The student took a spice packet from the nursing station and reentered Resident 40's room without performing hand hygiene, did not put on a gown or gloves, finished setting up the meal tray, and left the room without performing hand hygiene. Observation on 02/06/2026 at 08:17 AM showed Resident 40's room signage was changed to Contact Precautions Special Enteric. The sign instructed visitors to report to the nursing station before entering. The sign instructed everyone to wash their hands with soap and water before entering and leaving the room and showed an image of hands washing with soap under a water faucet. The sign directed staff to wear gloves and a gown upon entry and remove them before exiting, use disposable equipment when possible, and disinfect reusable items. Observation on 02/06/2026 at 12:10 PM showed Resident 40's meal tray was placed on top of the meal cart in the 300 East hallway. Resident 40's meal was on a tray inside disposable containers and cups with disposable utensils on the side. In an interview on 02/12/2026 at 12:20 PM, Staff B (Director of Nursing Services) and Staff K (Infection Preventionist) stated they expected staff and visitors to read and follow precaution signs posted outside resident rooms. Staff B stated students were expected to follow the instructions on the precaution signs in the same way staff would and ask questions when instructions were not clear. Staff K stated standard Contact Precautions were not appropriate for C. diff infections. Staff K stated Contact Precautions Specific Enteric were appropriate to prevent the spread of C. diff. to other residents and staff. Staff K stated hand sanitizer was an ineffective form of hand hygiene against C. diff and expected staff to wash their hands with soap and water. Staff B stated they expected appropriate signage to be posted and followed according to the infectious disease type, but they were not. Staff B stated they expected nursing staff to coordinate with kitchen staff to provide Resident 40 with disposable dishware that could be discarded inside the room, but they did not. In an interview on 02/12/2026 at 1:32 PM, Staff K stated they identified on 02/05/2026 the Contact Precaution signage outside Resident 40's room would not be effective to prevent the spread of C. diff and changed it to the Contact Precaution Specific Enteric. Staff K stated they should post the appropriate signage outside Resident 40's room but they did not. Staff K stated it was important to post the appropriate signage to identify specific techniques to prevent the spread of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<EBP/Wound Care> <Resident 44> According to the 12/19/2025 admission MDS, Resident 44 had venous insufficiency (a chronic condition where the leg veins do not send enough blood back to the heart) and a surgical wound. Review of a 01/31/2026 physician order showed Resident 44 was to receive wound care for their right ankle. Staff were to clean and dry the wound, apply a foam dressing, and cover the wound every other day shift. Observation on 02/10/2026 at 10:52 AM, Resident 44's room had an EBP sign posted on their door instructing staff to wear gloves and a gown while providing direct care. Observation showed Staff H (RN, Team Leader) providing wound care to Resident 44's right ankle wound. Staff H did not perform hand hygiene between changing from soiled to clean gloves. Staff H cut a piece of foam dressing using scissors that were not sanitized prior to use. After using the scissors, Staff H picked up the soiled wound dressings with the same hand that carried the scissors and put the scissors back into the nurse's treatment cart without sanitizing the scissors. In an interview on 02/10/2026 at 10:52 AM Staff H stated, they should have sanitized their hands between changing from soiled to clean gloves but did not. Staff H stated they should have sanitized the scissors prior to using them for wound care for Resident 44 but did not and should not have put the scissors back into the treatment cart without sanitizing them for infection control. In an interview on 02/10/2026 at 12:25 PM Staff K stated staff should anticipate the needs for supplies ahead of time and should sanitize all equipment for wound care before and after use to prevent the spread of infections. REFERENCE: WAC 388-97-1320(1)(a)(c)(2)(b).

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents' medication regimens were free of chemical restraints for 1 of 5 (Resident 11) residents whose medication regimens were reviewed. This failure left residents at risk for unneeded psychotropic medications, sedation, and a diminished quality of life. Findings included . <Facility Policy>According to the facility's revised 02/19/2025 Use of Psychotropic Medications policy, psychotropic medications affected brain function and should only be used to treat a specific, diagnosed, and documented condition for which the medication was beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication. The policy showed when a resident needed a psychotropic medication, their record must include a rationale for use, and the effects of the use of a psychotropic medication must evaluated on an ongoing basis.<Resident 11>According to the 12/30/2025 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 11 was sometimes understood others and was understood in conversation. The MDS showed Resident 11 had severely impaired cognition and diagnoses including dementia (a condition characterized by a progressive or persistent loss of intellectual function), anxiety, depression, and a psychotic disorder. The MDS showed Resident 11 took an Antipsychotic (AP) medication and admitted to the facility on [DATE]. Review of the physician's orders showed a 12/09/2025 order for an AP medication give 37.5 Milligrams (MG) at bedtime for unspecified dementia, unspecified severity. without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, and a 12/10/2025 order for the same AP medication, give 25 MG in the morning for unspecified dementia, unspecified severity. without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. The same medication was previously ordered on 10/09/2025 for dementia with psychosis, and on 10/17/2025 and 11/10/2025 for a neurocognitive disorder with psychotic features. The physician's orders also included a 10/10/2025 order for staff to monitor three different behaviors related to their dementia with psychosis diagnosis: delusional thinking, hallucinations, agitation. There was no order directing staff to monitor Resident 11 for orthostatic hypotension (the lowering of blood pressure when moving from lying to sitting or sitting to standing - a risk factor for falls that could be caused by AP medications). Record review showed Resident 11 was diagnosed on [DATE] (the date of their admission to the facility) with brief psychotic disorder.Review of the revised 10/10/2025 Mood Problem Related to a Diagnosis of Dementia with Psychosis CP showed the facility developed a goal for Resident 11 to have improved mood state as evidenced by a happier, calmer appearance, no [signs or symptoms] of depression, anxiety or sadness . This CP showed staff should monitor Resident 11's mood patterns for signs of depression, anxiety, and a sad mood. This CP showed staff should review Resident 11's behaviors, interventions, alternate therapies attempted, and their effectiveness with the physician and Resident 11's family.Review of the October 2025 Medication Administration Record (MAR) showed staff documented Resident 11 displayed a behavior of delusional thinking, hallucinations, or agitation on 11 of 64 shifts that month when the resident was in the facility. The October 2025 MAR did not indicate which of the three behaviors was observed by staff on a given occasion.Review of the November 2025 MAR showed Resident 11 displayed a behavior of delusional thinking, hallucinations, or agitation on two of 90 shifts that month. Review of the December 2025 MAR showed Resident 11 displayed a behavior of delusional thinking, hallucinations, or agitation on four of 93 shifts that month.Review of the January 2026 MAR showed Resident 11 displayed a behavior of delusional thinking, hallucinations, or agitation on three of 90 shifts that month.Review of the February 2026 MAR showed Resident 11 displayed no behaviors between 02/01/2026 and 02/08/2026 (the time of review).Review of the progress notes from admission on [DATE] through 02/09/2026 showed no staff documentation of any delusional behavior or hallucinations. The only behaviors discussed in progress notes were (continued on next page)

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	505475	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wesley Homes Des Moines Health Center	826 South 218th Street Des Moines, WA 98198

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	agitation (including yelling and screaming) and wandering. Observation on 02/05/2026 11:42 AM showed Resident 11 sitting in the chair next to their spouse. When asked by a surveyor if the person next to them was their spouse, Resident 11 became confused.Observation on 02/05/2026 1:19 PM showed Resident 11 walking towards their spouse's room. Resident 11 showed no signs of a diminished mood or any indication of distress. Observation on 02/09/2026 8:32 AM showed Resident 11 leaving their bedroom following an aide, with no signs of a diminished mood or any indication of distress. In an interview on 02/11/2026 at 1:00 PM Staff B (Director of Nursing Services) stated unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety was not an adequate rationale for the use of an AP medication. Staff B stated they expected staff to document all behaviors of concern related to psychotropic use, and if staff did not document such behaviors, they did not happen. Staff B stated the higher frequency of Resident 11's behaviors on admission was likely due to adjustment difficulty.In an interview on 02/12/2026 at 10:34 AM, Staff B stated it was important to monitor residents' orthostatic blood pressure when they took AP medications to help prevent falls.REFERENCE: WAC 388-97-1060(3)(k)(i), -0620(1)(a).

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review the facility failed to ensure comprehensive Care Plans (CPs) were developed and implemented for 5 (Residents 85, 44, 38, 10, & 9) of 20 sample residents reviewed. The failure to ensure all care needs were addressed by the CP placed residents at risk for unmet care needs, and frustration. Findings included .<Resident 85> According to the 02/10/2026 admission Minimum Data Set (MDS - an assessment tool) Resident 85 admitted to the facility after a surgical procedure involving their digestive system. The MDS showed Resident 38 had lower abdominal pain and a surgical wound. Review of Resident 85's comprehensive CP showed no directions to staff to provide post-surgical care of, or interventions for staff to monitor Resident 38's digestive system In an interview on 02/06/2026 at 7:57 AM, Resident 85 stated they had new pain in their abdomen and thought it could be related to gas pain from a surgery of their colon. Resident 85 stated some of the staff were very helpful in assisting them, however others did not seem to know them. Resident 85 stated one nurse stated they should lay flat for pain and another nurse told them to keep their knees up while in bed. Resident 85 stated it was as if the staff did not know what their needs were. In an interview on 02/10/206 at 8:46 AM, Resident 85 stated they had a bowel movement recently however it was not much. Resident 85 stated their bowel movements were still not as they expected them to be and they were unsure if staff monitored this. In an interview on 02/12/2026 at 9:14 AM with Staff F (Registered Nurse, Resident Care Manager) stated they expected Resident 85's CP to be comprehensive and sufficiently detailed so staff knew what to do to help with Resident 85's care issues. Staff F stated bowel monitoring should have been included in the CP, especially since Resident 85 had a recent bowel surgery, but was not. In an interview on 02/12/2026 at 9:59 AM Staff B (Director of Nursing) stated Resident 85's care needs should be addressed in their CP to provide staff direction all the resident's needs including pain and bowel monitoring. <Resident 44> According to the 01/19/2026 admission MDS, Resident 44 had Chronic Obstructive Pulmonary Disease (COPD - a respiratory disease) and required oxygen therapy. Review of the 01/26/2026 Pneumonia (a lung infection) CP showed staff were to provide oxygen per the physician orders. The CP did not include directions to monitor Resident 44's oxygen saturation (measurement of oxygen in the blood) levels. Review of a 01/28/2026 physician order, showed supplemental oxygen should be provided every shift with a goal of oxygen saturation over 88% for shortness of breath. Observation on 02/09/2026 at 8:49 AM showed Resident 44 not receiving supplemental oxygen at that time. Resident 44 stated they took the oxygen tubing off because the tubes bothered them. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 44's oxygen saturation rates showed staff did not document oxygen saturation rates on 02/08/2026, 02/09/2026 and 02/10/2026. In an interview on 02/12/226 at 9:32 AM Staff F stated staff should implement the CP and check oxygen saturations every shift and monitor and document Resident 44's oxygen levels. In an interview on 02/12/2026 at 10:12 AM, Staff B stated staff should check oxygen saturations for any resident on oxygen and document their progress per the CP. <Resident 38> According to the 01/02/2026 Quarterly MDS, Resident 38 had diagnoses that included heart failure, hypertension, and generalized edema. Review of the revised 09/29/2025 Altered Respiratory Status/Difficulty breathing related to Shortness of Breath due to Heart Failure CP showed staff should monitor for symptoms of respiratory distress and report symptoms of abnormal breathing patterns to Resident 38's provider. Observation on 02/11/2026 at 9:05 AM showed Resident 38 coughing repeatedly. In an interview on 02/12/2026 at 8:50 AM, Resident 38 stated they coughed all night the previous night. Resident 38 stated they raised the head of their bed up so they could breathe better and not cough, and stated they were dizzy and lightheaded during the night. Resident 38 was observed with a productive cough and had shortness of breath while talking. Review of Resident 38's progress notes did not show their provider was notified of increase in coughing or shortness of breath. In an interview on 02/12/2026 at 9:39 AM, Staff F stated staff should be following directions as shown on the CP. In an interview on 02/12/2026 at 10:16 AM, Staff B stated if a resident had edema or coughing, staff were expected to call the provider and give an update. Staff B stated if there were any changes in directions, that should also be reflected in the CP. <Resident 10> According to the 01/23/2026 admission MDS, Resident 10 had diagnoses including atrial fibrillation (irregular heart rhythm) and took a blood thinner. Review of a 01/26/2026 physician order showed Resident 10 took a blood thinner medication daily and staff should observe for discolored urine, black tarry stools, headache, nausea, vomiting, shortness of breath, and nose bleeds and document the results every day. Review of Resident 10's comprehensive CP showed the CP did not reflect Resident 10's blood thinner medication use and did not show what side effects to observe for. Review of the February 2026 Kardex (caregiver task sheet) did not identify the side effects of blood thinner medication and what care staff should observe and report. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/12/2026 at 9:37 AM, Staff F stated staff should monitor for side effects of the blood thinner as blood thinner could easily cause bleeding. Staff F stated the side effects should be listed on the CP and Kardex but were not. In an interview on 02/12/2026 at 10:14 AM Staff B stated blood thinner side effects should be on the CP and Kardex for staff to know what to look for and what to report on but were not. <Resident 9> According to the 12/19/2025 Quarterly MDS, Resident 9 had diagnoses including a mental health disorder. The MDS showed Resident 9 took an antipsychotic medication. Review of the physician's orders showed two 01/08/2026 orders for an antipsychotic medication: give 12.5 Milligram (MG) by mouth in the morning related to their mental health disorder; give 25 MG tablet by mouth at bedtime related to their mental health disorder. Record review showed a revised 08/28/2025 Resident uses psychotropic medications . CP. This CP's only goal was to remain free of drug-related complications from the treatment. No goal related to any potential benefit of the medication was developed. In an interview on 02/11/2026 at 1:20 PM, Staff B reviewed the CP and stated the only goal was to avoid complications. Staff B stated the CP should include a goal addressing the potential benefit of the treatment. REFERENCE: WAC 388-97-1020(1)(2)(a)(b).

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on interview and record review, the facility failed to ensure care and services were provided within professional standards of nursing for 2 (Residents 8 & 63) of 5 residents whose medication regimen was reviewed. The failure to ensure orders were clarified when needed placed residents at risk for unneeded care and unmet care needs. Findings included . <Facility Policy>According to facility's 02/19/2025 Use Of Medications(s) policy, psychotropic medications should only be used after a practitioner determined that the medication(s) was appropriate to treat a resident's specific, diagnosed, and documented condition.<Clarifying Orders><Resident 8>According to the 11/22/2025 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 8 had diagnoses including a stroke history, an intestinal obstruction, and a history of digestive surgery. The MDS showed Resident 8 had an ileostomy (a surgical hole through which waste passes directly from the small intestine). Record review showed the following physician's orders for Resident 8: a 11/19/2025 order to change Resident 8's colostomy (a surgical hole through which waste passes directly from the colon - not an ileostomy) bag; a 11/19/2025 order to change Resident 8's ileostomy wafer (a specialized dressing for ostomy care) that showed Wafer size ____. Change wafer every 7 days and did not specify what size wafer to use.Review of the February 2026 MAR showed the orders for the wafer change and ostomy bag change were not included. There was nowhere for nurses to document the care provided.In an interview on 02/11/2026 10:03 AM, Staff G (Registered Nurse, Team Leader) stated when changing Resident 8's wafer they would review the order to see what size wafer to use.Observation on 02/06/2026 at 9:34 AM showed Resident 8 in bed with an ileostomy bag connected to their torso. Resident 8 stated staff cared for the ileostomy well.In an interview on 02/11/2026 at 1:30 PM, Staff B (Director of Nursing Services) stated the wafer order should specify what size wafer, and nurses should have identified the order needed clarifying but did not. Staff B stated nurses should have identified the colostomy bag order needed to be changed to an ileostomy bag but did not. Staff B stated both orders should have been added to the MAR but were not. <Resident 63>According to the 01/16/2026 Quarterly MDS, Resident had severely impaired cognition and altered level of consciousness. The MDS showed Resident 63 had diagnoses including vascular dementia and a psychotic disorder. Review of the physician's orders showed the following: a 09/26/2025 order for an antipsychotic medication, give 12.5 mg by mouth in the morning for vascular dementia; a 09/26/2025 order for an antipsychotic medication, give 25 mg by mouth in the evening for vascular dementia.In an interview on 02/11/2026 at 1:15 PM, Staff B stated the rationale for the antipsychotic medication was incorrect. Staff B stated the order should show Resident 63's psychotic disorder was the rationale for the medication, and nurses should have, but did not identify the error.REFERENCE: WAC 388-97-1620(2)(b)(i)(ii)(6)(b)(i).

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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. Based on observation, interview, and record review the facility failed to ensure residents received the assistance they were assessed to require with Activities of Daily Living (ADL) for 1 (Resident 78) of 2 residents reviewed for ADL. This failure placed residents at risk for poor hygiene, odors, skin irritation, and a diminished sense of self-worth.Findings included .<Facility Policy>According to the revised 07/26/2024 ADL Policy, the facility would provide the care and services residents were assessed to require related to bathing, dressing, and grooming. The policy showed residents who could not carry out their own ADL would receive the help they needed.<Resident 78>According to the 12/15/2025 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 78 had moderately impaired cognition and limited range of motion in their left arm and leg. This MDS showed Resident 78 was dependent on staff for transferring from their bed to a chair and was always incontinent of bowel and bladder. The MDS showed bathing preferences were very important for Resident 78.In an interview on 02/06/2026 at 9:15 AM Resident 78 stated they were unable to do much for themselves. At this time Resident 78 was in bed in a gown with their hair unkempt and a stained pink neck pillow supporting their head.Observation on 02/09/2026 at 12:25 PM showed Resident 78 in bed watching television, not dressed, with the same stained pink neck pillow around their neck and messy hair.Review of the physician's orders showed a 02/21/2025 order showing SHOWER DAY Document if patient received Shower or Bed-Bath or Refused. If refused, please place progress note with reason for refusal . The order directed staff to document notification of refusals to the resident's representative every Saturday.According to the 09/09/2020 ADL self-care performance deficit . Care Plan (CP), Resident 78 required total assistance from one staff for bathing and showering.Review of the bathing records showed from 01/23/2026 through 02/12/2026 showed no showers, baths, or bed baths provided and no documented refusals of bathing for Resident 78. Review of the progress notes showed no notes written by staff to document a bath or a shower was provided to Resident 78 over that period, and no documentation of any bathing refusals. In an interview on 02/12/2026 at 10:34 AM Staff B (Director of Nursing Services) stated Resident 78 should be provided bathing as ordered and care planned. Staff B stated they expected staff to document any care provided and note any refusals. REFERENCE: WAV 388-97-1060(2)(c).

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview, and record review, the facility failed to ensure adequate monitoring for fluid overload and edema (an abnormal buildup of fluid in bodily tissue) for 1 (Resident 38) of 2 residents reviewed for edema and failed to monitor oxygen therapy for 1 (Resident 38) of 2 residents receiving oxygen therapy. These failures to monitor for edema and to provide oxygen monitoring left residents at risk for respiratory discomfort, oxygen-related accidents, infection, and a decreased quality of life. Findings included. <Facility Policy>Review of the facility's revised 07/26/2024 Edema management policy showed the facility would manage edema by assessing the resident and following the medical practitioner's orders.Review of the facility's revised 07/09/2024 Oxygen Administration policy, showed oxygen therapy should be administered under orders of a physician. The policy showed staff would document the ongoing assessment of the resident's conditions warranting oxygen and their response to oxygen therapy. Staff were to document how often to administer oxygen such as continuous or intermittent and when to discontinue oxygen therapy. The policy showed to monitor oxygen saturation levels as ordered.<Resident 38> <Edema> According to the 01/02/2026 Quarterly Minimum Data Set (MDS-an assessment tool), Resident 38 had diagnoses including heart failure, high blood pressure, and generalized edema. Review of the 09/29/2025 Fluid Overload or Potential Fluid Volume Overload related to Heart Failure Care Plan (CP) showed staff would monitor, document, and report symptoms of fluid overload such as edema, coughing, shortness of breath, or difficulty breathing while lying flat. Observation on 02/11/2026 at 9:05 AM showed Resident 38 coughing repeatedly. At that time, Resident 38 stated they had a deep cough and could not get rid of it. Resident 38 stated they wished they had cough medicine because they could not sleep last night because of coughing and shortness of breath. In an interview on 02/12/2026 at 8:50 AM, Resident 38 stated they coughed throughout the previous night. Resident 38 stated they raised the head of their bed up so they could breathe better because lying flat made them cough more. Resident 38 stated they were dizzy and lightheaded during the night. At that time Resident 38 was observed with a productive cough and had shortness of breath while talking. Review of the February 2026 Medication Administration Record (MAR) showed staff gave Resident 38 cough medication on 02/11/2026 and staff indicated it was effective. No further documentation was found to show a respiratory assessment was completed, or other interventions were provided to Resident 38 for their cough. The residents' record did not show Resident 38's provider was notified of the increase in coughing or shortness of breath. In an interview on 02/12/2026 at 9:10 AM, Staff E (Registered Nurse - RN, Team Leader) stated they were aware Resident 38 had a cough the prior day. Staff E stated Resident 38's vitals were checked that day, and their blood pressure was low. In an interview on 02/12/2026 at 9:39 AM, Staff F (RN, Resident Care Manager), stated Resident 38 had chronic heart failure, edema, and a long-term cough. Staff F stated Resident 38 could easily get sick and their coughing should be assessed due to their medical conditions. Staff F stated staff (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should have assessed Resident 38's cough, checked for edema, and notified the provider of a change in condition related to fluid overload but did not. In an interview on 02/12/2026 at 10:21 AM Staff B (Director of Nursing Services), stated staff should have monitored Resident 38 for edema and fluid overload, and stated they expected nurses to document their findings and notify the provider, but did not. <Oxygen Monitoring> Review of the revised 09/29/2025 altered respiratory status/difficulty breathing related to shortness of breath due to heart failure CP showed the goal for Resident 38 was to not have complications related to their shortness of breath. Interventions on the CP showed staff would monitor symptoms of respiratory distress and report symptoms of abnormal breathing patterns to Resident 38's provider. Review of Resident 38's physician's orders showed a discontinued oxygen order for 2 liters per minute of oxygen to be provided as needed. There was no current order for oxygen therapy in Resident 38's medical record. Review of the February 2026 MAR did not show an oxygen order and did not show staff were to monitor Resident 38's oxygen levels. Observation on 02/05/2026 at 12:52 PM showed Resident 38 had an oxygen concentrator (a medical device that filters surrounding air to deliver medical-grade oxygen to treat low blood oxygen saturation). At that time, Resident 38 stated they used oxygen only at night. In an interview on 02/12/2026 at 8:50 AM, Resident 38 stated they used their oxygen concentrator the previous night and could not recall the rate the concentrator was set to. In an interview on 02/12/2026 at 9:10 AM, Staff E stated they were aware Resident 38 had breathing treatments twice that day and had oxygen in their room. In an interview on 02/12/2026 at 9:39 AM, Staff F stated if a resident used oxygen there should be a current physician's order for the oxygen and the nurses should monitor the oxygen usage, oxygen saturations, and observe for shortness of breath. Staff F stated they did not know there was not a current order for oxygen usage for Resident 38 and stated nurses should have noticed and obtained orders from the provider but did not. In an interview on 02/12/2026 at 10:12 AM, Staff B stated an order for oxygen should have been in place for Resident 38 but was not. Staff B stated since Resident 38 had an oxygen concentrator in their room and received breathing treatments, the nurses should have checked for oxygen orders, assessed Resident 38, and notified the provider to ensure oxygen levels were correct for Resident 38. REFERENCE: WAC 388-97-1060(1).

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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. Based on observation, interview, and record review the facility failed to ensure residents received the care and services necessary to ensure their safety for 1 (Resident 11) of 1 residents reviewed for elopement risks. The failure placed the resident at risk for elopement, lack of supervision, and accidents.Findings included .<Facility Policy>According to the facility's revised 07/26/2024 Elopement and Wandering Residents policy, the facility would ensure all residents who wandered or were assessed to be at risk for elopement would receive the supervision they needed to prevent accidents. The policy showed residents would be assessed for wandering risk upon admission and a person-centered Care Plan (CP) with interventions developed to minimize risks associated with wandering.<Resident 11>According to the 12/30/2025 Quarterly Minimum Data Set (MDS - An assessment tool) Resident 11 sometimes understood others and was sometimes understood during conversation. The MDS showed Resident 11 was assessed to have severely impaired cognition and behavior including wandering. The MDS showed Resident 11 had diagnoses including dementia. According to the 10/06/2025 Elopement Risk Assessment, Resident 11's dementia diagnosis placed them at risk for wandering. This assessment showed Resident 11 could ambulate independently, verbalized their desire to go home from the facility, had an elopement history at their prior residence and at the facility, and took medications that altered their mental status. Review of the physician's orders showed a 10/07/2025 order for staff to check the placement of a wander alarm (a device placed on the resident's body that made a sound when the resident got to close to an exit) on Resident 11's anklefor resident is at wander risk. There was no order for staff to check the function of the alarm. According to the 10/07/2025 elopement risk CP, Resident 11's goals were to not leave the facility unattended, and to maintain their safety. This CP included an intervention of a wander alarm. The CP identified the wander alarm as a safety device. Observation on 02/05/2026 at 1:20 PM showed Resident 11 wandering on their unit near their spouse's room without any clear purpose.In an interview on 02/12/2026 at 10:34 AM, Staff B (Director of Nursing Services) stated when a resident was assessed to require a wander alarm, it was important to check the device frequently to ensure it was working correctly. Staff B stated wander alarms should be checked each shift. Staff B stated Resident 11 should have an order in place for staff to check the function of the wander alarm, but there was no such order.REFERENCE: WAC 388-97-1060(3)(g).