

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505478	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/14/2025
NAME OF PROVIDER OR SUPPLIER Corwin Center at Emerald Heights		STREET ADDRESS, CITY, STATE, ZIP CODE 10901 - 176th Circle Northeast Redmond, WA 98052	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48899</p> <p>Based on interview and record review, the facility failed to ensure residents were protected from misappropriation of controlled (narcotic or opioid) medication for 1 of 3 residents (Resident 1), reviewed for misappropriation of controlled medications. This failure placed the resident at risk for pain, unmet care needs, ongoing misappropriation of medications, and a diminished quality of life.</p> <p>Findings included .</p> <p>Review of the facility's policy titled, Freedom from Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property, revised in August 2024, showed Misappropriation of Resident Property: The deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent.</p> <p>Review of the facility's policy titled, Controlled Substances, revised in November 2011, showed that nursing staff must count controlled drugs at the end of each shift and the nurse coming on duty and the nurse going off duty must make the count together and sign off that the count was correct and they must document and report any discrepancies to the Director of Nursing Services (DNS) or designee.</p> <p>Review of the discharge Minimum Data Set (MDS-as assessment tool) dated 01/14/2025 showed that Resident 1 admitted to the facility on [DATE]. The MDS also showed that Resident 1 was on hospice care (comfort care-end of life care).</p> <p>Review of the December 2024 and January 2025 Medication Administration Record showed an order dated 09/13/2024 for morphine (a narcotic medication used to relieve severe pain) concentrate oral solution, give 0.25 milliliter (ml- a unit of measurement) three times a day for pain.</p> <p>(continued on next page)</p>

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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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of the facility's investigative report dated 01/21/2025, showed that on 01/11/2025 Staff F, Registered Nurse (RN), reported that there was a discrepancy of a liquid morphine for Resident 1. The report showed that the expected amount of morphine was two [2] ml, but it was found at 0.75 ml and that both the incoming nurse [Staff F] and the outgoing nurse [Staff G, RN] that day measured the amount of morphine together and corrected the narcotic ledger (a log used to track the administration and inventory of controlled substances such as morphine). The investigative report showed that on 01/13/2025, Staff F reported another inconsistency that Resident 1's liquid morphine bottle was at a higher level and the count was off again [unknown how the morphine was off]. The investigative report showed that on 01/16/2025, another bottle of morphine for Resident 1 was also not [the] correct color and had a sweet odor. The facility's investigative report included another narcotic discrepancy for another resident [Resident 2] on 01/16/2025, it showed that Staff C, Licensed Practical Nurse (LPN), noticed that a bottle of liquid morphine for the resident [Resident 2] was different in color as well as smelled sweet. Then on 01/17/2025, the investigative report showed, Staff D, LPN, reported that the bottle of liquid morphine for another resident [Resident 3] showed it did not look right and it was over filled. The investigative report showed that the facility discovered that Staff E, LPN, was reported to have some poor nursing practice since coming of orientation, including leaving keys on top of a medication cart unattended after her shift, staff having difficulty finding her during her shift and that she often out of the building. Further review of the investigation report showed the alleged diversion likely done by the new employee [Staff E].</p> <p>Review of the narcotic ledger showed that on 01/11/2025 at 3:45 PM, the morphine count was recorded as 0.75 ml, with the amount being verified and signed by Staff F and Staff G. The narcotic ledger showed that 0.25 ml of morphine was given to Resident 1 on 01/11/2025 at 8:00 PM, on 01/12/2025 at 8:07 AM, and on 01/12/2025 at 2:09 PM. The narcotic ledger showed that on 01/13/2025, the morphine count was recorded as 1.01 ml, and the expected amount should have been zero ml.</p> <p>In an interview on 02/13/2025 at 1:03 PM, Staff F stated that during their shift on 01/11/2025, they noticed a discrepancy in Resident 1's liquid morphine and reported it to Staff B [DNS]. Staff F stated that the morphine count was recorded as 2 ml, but upon measuring it, they found it to be 0.75 ml. Staff F stated that Staff B instructed them to measure the amount of morphine with Staff G and sign it. Staff F stated that they measured the morphine properly with Staff G, and the correct amount was 0.75 ml. Staff F stated that on 01/11/2025 at 8:00 PM, they administered 0.25 ml of morphine to Resident 1 and documented 0.50 ml as the remaining amount on the narcotic ledger. Staff F stated that on 01/12/2025 when they came back and measured the remaining amount of morphine, they noticed another discrepancy. Staff F stated that they found 1.01 ml of morphine when the expected amount was zero ml. Staff F stated they again reported the discrepancy to Staff B immediately.</p> <p>In an interview on 02/13/2025 at 1:43 PM, Collateral Contact 1 (CC1) stated that they have heard from the facility about the allegations of Resident 1's morphine diversion reported to Staff B on 01/11/2025 and 01/12/2025, but no one notified them until 01/17/2025. CC1 stated that Staff B allowed the staff involved to continue working and did not notify the State Agency, resident representative, and/or the police until 01/17/2025. CC1 further stated that they did not know whether the allegations reported on 01/11/2025 and 01/13/2025 were [thoroughly investigated to determine the root cause.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>In an interview on 02/13/2025 at 2:05 PM, CC2 stated that they were unaware of the allegations of morphine discrepancies dated on 01/11/2025, 01/12/2025, or 01/16/2025. CC2 stated that the facility should have informed them on the investigation results and that they would not have to worry about whether these allegations might have contributed to medication diversion potentially led to Resident 1's passing on 01/15/2025.</p> <p>In an interview on 02/13/2025 at 2:20 PM, Staff G, stated that during their shift on 01/11/2025, they noticed that the amount of liquid morphine left for Resident 1 and what was recorded on the narcotic ledger did not match. Staff G stated they attempted to measure and verify the amount with Staff E, but Staff E had told them they were in rush and left without verifying it. Staff G stated that they realized there was a discrepancy on the amount of the liquid morphine for Resident 1, but they did not report it to the facility nursing management. Staff G stated, that was my mistake. Staff G stated that they administered 0.25 ml of morphine to Resident 1 during their shift with the expected amount left being 2 ml. Staff G stated that when they measured the morphine with the incoming nurse (Staff F) the correct amount was 0.75 ml and they both signed it.</p> <p>In an interview on 02/14/2025 at 10:29 AM, Staff B stated that they had received reports regarding morphine discrepancies for Resident 1 on Saturday [01/11/2025], Sunday [01/12/2025], and 01/16/2025. Staff B stated upon receiving the allegation on 01/11/2025, they instructed Staff F to measure the amount properly with Staff G, correct the narcotic ledger, and sign it. When asked about the discrepancies on the narcotic ledger for Resident 1 on 01/11/2025 and 01/12/2025, Staff B stated that discrepancies like that were expected with liquid medications including morphine. Staff B stated that the morphine count was off on Sunday [01/12/2025] because, I assumed that Staff E and Staff G did not empty the bottle when they measured it on 01/11/2025. Staff B further stated that their investigation into the allegation from 01/16/2025 was substantiated.</p> <p>In an interview on 02/14/2025 at 1:58 PM, Staff A, Administrator, stated that for medication diversion allegations related to Resident 1, they would expect the facility staff to follow the facility's policy to protect residents from the misappropriation of their property.</p> <p>Reference: (WAC) 388-97-0640 (2)(a), (3)(c)(d)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48899</p> <p>Based on interview and record review, the facility failed to timely report allegations of misappropriation of controlled (narcotic or opioid) medication to the State Agency within the required timeframe for 1 of 3 residents (Resident 1), reviewed for allegations of misappropriation. This failure placed the resident at risk for potential unidentified abuse and lack of protection from misappropriation.</p> <p>Findings included .</p> <p>Review of the facility's policy titled, Freedom from Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property, revised in August 2024, showed The Facility shall report abuse allegations per Federal and State Law.</p> <p>Review of the facility's policy titled, Controlled Substances, revised in November 2011, showed that nursing staff must count controlled drugs at the end of each shift and the nurse coming on duty and the nurse going off duty must make the count together and sign off that the count was correct and they must document and report any discrepancies to the Director of Nursing Services (DNS) or designee.</p> <p>Review of the discharge Minimum Data Set (MDS-as assessment tool) dated 01/14/2025 showed that Resident 1 admitted to the facility on [DATE]. The MDS also showed that Resident 1 was on hospice care (comfort care-end of life care).</p> <p>Review of the December 2024 and January 2025 Medication Administration Record showed an order dated 09/13/2024 for morphine (a narcotic medication used to relieve severe pain) concentrate oral solution, give 0.25 milliliter (ml-a unit of measurement) three times a day for pain.</p> <p>Review of January 2025 nursing progress note did not show that the allegations of Resident 1's liquid morphine discrepancies on 01/11/2025 and 01/13/2025 were reported to the State Agency.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of facility's investigative report dated 01/21/2025, showed that on 01/11/2025 Staff F, Registered Nurse (RN), reported that there was a discrepancy of a liquid morphine for Resident 1. The report showed that the expected amount of morphine was two [2] ml, but it was found at 0.75 ml and that both the incoming nurse [Staff F] and the outgoing nurse [Staff G, RN] that day measured the amount of morphine together and corrected the narcotic ledger (a log used to track the administration and inventory of controlled substances such as morphine). The investigative report showed that on 01/13/2025, Staff F reported another inconsistency that Resident 1's liquid morphine bottle was at a higher level and the count was off again [unknown how the morphine was off]. The investigative report showed that on 01/16/2025, another bottle of morphine for Resident 1 was also not [the] correct color and had a sweet odor. The facility's investigative report included another narcotic discrepancy for another resident [Resident 2] on 01/16/2025, it showed that Staff C, Licensed Practical Nurse (LPN), noticed that a bottle of liquid morphine for the resident [Resident 2] was different in color as well as smelled sweet. Then on 01/17/2025, the investigative report showed that Staff D, LPN, reported that the bottle of liquid morphine for another resident [Resident 3] showed that it did not look right and it was over filled. The investigative report showed that the facility discovered that Staff E, LPN, was reported to have some poor nursing practice since coming of orientation, including leaving keys on top of a medication cart unattended after her shift, staff having difficulty finding her during her shift and that she often out of the building. Further review of the investigation report showed the alleged diversion likely done by the new employee [Staff E].</p> <p>Review of the narcotic ledger showed that on 01/11/2025 at 3:45 PM, the morphine count was recorded as 0.75 ml, with the amount being verified and signed by Staff F and Staff G. The narcotic ledger showed that 0.25 ml of morphine was given to Resident 1 on 01/11/2025 at 8:00 PM, on 01/12/2025 at 8:07 AM, and on 01/12/2025 at 2:09 PM. The narcotic ledger showed that on 01/13/2025, the morphine count was recorded as 1.01 ml, and the expected amount should have been zero ml.</p> <p>In an interview on 02/13/2025 at 11:26 AM, Staff H, Pharmacy Consultant, stated that they would expect the staff to report any discrepancies in narcotic medication counts to the DNS [Staff B]. Staff H stated that they were unaware of the morphine count discrepancies for Resident 1 that were reported on 01/11/2025 and 01/12/2025. Staff H stated that they were aware of the allegation that was reported on 01/16/2025. Staff H did not recall the exact date when they were informed about the allegation from 01/16/2025 but believed it was during the week of January 13th [01/13/2025] to the 17th [01/17/2025].</p> <p>In an interview on 02/13/2025 at 1:03 PM, Staff F, stated that during their shift on 01/11/2025, they noticed a discrepancy in Resident 1's liquid morphine and reported it to Staff B. Staff F stated that the morphine count was recorded as 2 ml, but upon measuring, they found it to be 0.75 ml. Staff F stated that Staff B instructed them to measure the amount of morphine with Staff G and sign it. Staff F stated that they measured the morphine properly with Staff G, and the correct amount was 0.75 ml. Staff F stated that on 01/11/2025 at 8:00 PM, they administered 0.25 ml of morphine to Resident 1 and documented 0.50 ml of morphine as the remaining amount on the narcotic ledger. Staff F stated that on 01/12/2025 when they came back and measured the remaining amount of morphine, they noticed another discrepancy. Staff F stated that they found 1.01 ml of morphine when the expected amount was zero ml. Staff F stated they again reported the discrepancy to Staff B immediately.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>In an interview on 02/13/2025 at 1:43 PM, Collateral Contact 1 (CC1) stated that they have heard from the facility nurses about allegations of Resident 1's morphine diversion reported to the Staff B on 01/11/2025 and 01/12/2025, but no one notified them until 01/17/2025. CC1 stated that Staff B allowed the staff involved to continue working and did not notify the State Agency, resident representative, and/or the police until 01/17/2025.</p> <p>In an interview on 02/13/2025 at 2:05 PM, CC2 stated that they were unaware of the allegations of morphine discrepancies dated on 01/11/2025, 01/12/2025, or 01/16/2025. CC2 stated that the facility should have informed them on the investigation results and that they would not have to worry about whether these allegations might have contributed to medication diversion potentially led to Resident 1's passing on 01/15/2025.</p> <p>In an interview on 02/13/2025 at 2:20 PM, Staff G, stated that during their shift on 01/11/2025, they noticed that the amount of liquid morphine left for Resident 1 and what was recorded on the narcotic ledger did not match. Staff G stated they attempted to measure and verify the amount with Staff E, but Staff E had told them they were in a rush and left without verifying it. Staff G stated that they realized there was a discrepancy on the amount of the liquid morphine for Resident 1, but they did not report it to the facility nursing management. Staff G stated, that was my mistake. Staff G stated that they administered 0.25 ml of morphine to Resident 1 during their shift with the expected amount left being 2 ml. Staff G stated that when they measured the morphine with the incoming nurse (Staff F) the correct amount was 0.75 ml and they both signed it.</p> <p>In an interview on 02/14/2025 at 10:29 AM, Staff B stated that they had received reports regarding morphine discrepancies for Resident 1 on Saturday [01/11/2025], Sunday [01/12/2025], and on 01/16/2025. Staff B stated upon receiving the allegation on 01/11/2025, they instructed Staff F to measure the amount properly with Staff G, correct the narcotic ledger, and sign it. When asked about the allegations on narcotic discrepancies on 01/11/2025 and 01/12/2025, Staff B stated that they did not report it because discrepancies like the one reported on 01/11/2025 was expected with liquid medications, including morphine. Staff B stated that the morphine count on 01/12/2025 was off because I assumed that Staff E and Staff G did not empty the bottle. Staff B further stated that they did not report the allegations from 01/11/2025 and 01/12/2025 to the State Agency because they had no reasonable cause to report the allegations.</p> <p>In an interview on 02/14/2025 at 1:58 PM, Staff A, Administrator, stated that for medication diversion allegations related to Resident 1, they would expect the facility staff to follow the facility's reporting policy to protect residents from the misappropriation of their property.</p> <p>Reference: (WAC) 388-97-0640 (5)(a)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48899</p> <p>Based on interview and record review, the facility failed to timely initiate and/or thoroughly investigate allegation of misappropriation of controlled (narcotic or opioid) medication for 1 of 3 residents (Resident 1), reviewed for abuse investigation. This failure placed the resident at risk for pain, ongoing misappropriation, unidentified abuse, and inappropriate corrective actions.</p> <p>Findings included .</p> <p>Review of the facility's policy titled, Freedom from Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property, revised in August 2024, showed, The Facility shall promptly and thoroughly investigate any reports of abuse. The policy further showed that the investigation is the process used to try to determine what happened and designated facility personnel shall begin the investigation immediately and root cause investigation and analysis shall be completed.</p> <p>Review of the discharge Minimum Data Set (MDS-as assessment tool) dated 01/14/2025 showed Resident 1 admitted to the facility on [DATE]. The MDS also showed that Resident 1 was on hospice care (comfort care-end of life care).</p> <p>Review of the December 2024 and January 2025 Medication Administration Record showed an order dated 09/13/2024 for morphine (a narcotic medication used to relieve severe pain) concentrate oral solution, give 0.25 milliliter (ml-a unit of measurement) three times a day for pain.</p> <p>Review of facility's investigative report dated 01/21/2025, showed that on 01/11/2025 Staff F, Registered Nurse (RN), reported that there was a discrepancy of a liquid morphine amount for Resident 1. The report showed that the expected amount of morphine was measured [2] ml, but it was found at 0.75 ml and that both the incoming nurse [Staff F] and the outgoing nurse [Staff G, RN] that day measured the amount of morphine together and corrected the narcotic ledger (a log used to track the administration and inventory of controlled substances such as morphine). The investigative report showed that on 01/13/2025, Staff F reported another inconsistency that Resident 1's liquid morphine bottle was at a higher level and the count was off again [unknown how the morphine was off]. The investigative report showed that on 01/16/2025, another bottle of morphine for Resident 1 was also not [the] correct color and had a sweet odor. The facility's investigative report included another narcotic discrepancy for another resident [Resident 2] on 01/16/2025, it showed that Staff C, Licensed Practical Nurse (LPN), noticed that a bottle of liquid morphine for another resident [Resident 2] was different in color as well as smelled sweet. Then on 01/17/2025, the investigative report showed that Staff D, LPN, reported that a bottle of liquid morphine for another resident [Resident 3], and stated it did not look right and it was over filled. The investigative report showed that the facility discovered that Staff E, LPN, was reported to have some poor nursing practice since coming of orientation, including leaving keys on top of a medication cart unattended after her shift, staff having difficulty finding her during her shift and that she often out of the building. Further review of the investigation report showed the alleged diversion likely done by the new employee [Staff E].</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of the narcotic ledger showed that on 01/11/2025 at 3:45 PM, the morphine count was recorded as 0.75 ml, with the amount being verified and signed by Staff F and Staff G. The narcotic ledger showed that 0.25 ml of morphine was given to Resident 1 on 01/11/2025 at 8:00 PM, on 01/12/2025 at 8:07 AM, and on 01/12/2025 at 2:09 PM. The narcotic ledger showed that on 01/13/2025, the morphine count was recorded as 1.01 ml, and the expected amount should have been zero ml.</p> <p>In an interview on 02/13/2025 at 1:03 PM, Staff F stated that during their shift on 01/11/2025, they noticed a discrepancy in Resident 1's liquid morphine and reported it to Staff B, Director of Nursing Services. Staff F stated that the morphine count was recorded as 2 ml, but upon measuring it, they found it to be 0.75 ml. Staff F stated that Staff B instructed them to measure the amount of morphine with Staff G and sign it. Staff F stated that they measured the morphine properly with Staff G, and the correct amount was 0.75 ml. Staff F stated that on 01/11/2025 at 8:00 PM, they administered 0.25 ml of morphine to Resident 1 and documented 0.50 ml as the remaining amount on the narcotic ledger. Staff F stated that on 01/12/2025 when they came back and measured the remaining amount, they noticed another discrepancy. Staff F stated that they found 1.01 ml of morphine when the expected amount was zero ml. Staff F stated they again reported the discrepancy to Staff B immediately. Staff F stated that they did not believe the allegations they reported on 01/11/2025 and 01/12/2025 were investigated because no one contacted them to inquire about the allegations, despite having reported them and the alleged staff was still on the schedule. Staff F further stated that they were unaware of the outcomes of the allegations they reported on 01/11/2025 and 01/12/2025.</p> <p>In an interview on 02/13/2025 at 1:43 PM, Collateral Contact 1 (CC1) stated that they have heard from the facility about the allegations Resident 1's morphine diversion reported to Staff B on 01/11/2025 and 01/12/2025, but no one notified them until 01/17/2025. CC1 stated that Staff B allowed the staff involved to continue working and did not notify the State Agency, resident representative, and/or the police until 01/17/2025. CC1 further stated that they did not know whether the allegations reported on 01/11/2025 and 01/12/2025 were [thoroughly] investigated to determine the root cause.</p> <p>In an interview on 02/13/2025 at 2:05 PM, CC2 stated that they were unaware of the allegations of morphine discrepancies dated on 01/11/2025, 01/12/2025, or 01/16/2025. CC2 stated that the facility should have informed them on the investigation results and that they would not have to worry about whether these allegations might have contributed to medication diversion potentially led to Resident 1's passing on 01/15/2025.</p> <p>In an interview on 02/13/2025 at 2:20 PM, Staff G, stated that during their shift on 01/11/2025, they noticed that the amount of liquid morphine left for Resident 1 and what was recorded on the narcotic ledger did not match. Staff G stated they attempted to measure and verify the amount with Staff E, but Staff E had told them they were in a rush and left without verifying it. Staff G stated that they realized there was a discrepancy on the amount of the liquid morphine for Resident 1, but they did not report it to the facility nursing management. Staff G stated, that was my mistake. Staff G stated that they administered 0.25 ml of morphine to Resident 1 during their shift with the expected amount left being 2 ml. Staff G stated that when they measured the morphine with the incoming nurse (Staff F) the correct amount was 0.75 ml and that they both signed it. Staff G stated that they were unsure whether the allegation from 01/11/2025 was investigated, as they did not communicate with them after they measured the morphine and signed the narcotic ledger with Staff F on 01/11/2025.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505478	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/14/2025
NAME OF PROVIDER OR SUPPLIER Corwin Center at Emerald Heights		STREET ADDRESS, CITY, STATE, ZIP CODE 10901 - 176th Circle Northeast Redmond, WA 98052	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>In an interview on 02/14/2025 at 10:29 AM, Staff B stated that they had received reports regarding morphine discrepancies for Resident 1 on Saturday [01/11/2025], Sunday [01/12/2025], and 01/16/2025. Staff B stated that upon receiving the allegation on 01/11/2025, they instructed Staff F to measure the amount of morphine properly with Staff G, and correct the narcotic ledger, and sign it. When asked about the allegations on narcotic discrepancies on 01/11/2025 and 01/12/2025. Staff B stated that the morphine count for Resident 1 was off on 01/11/2025 on the narcotic ledger because it was sometimes expected and the morphine was off on 01/12/2025 because I assumed that Staff E and Staff G did not empty the bottle when they measured it.</p> <p>In an interview on 02/14/2025 at 1:58 PM, Staff A, Administrator, stated that for medication diversion allegations related to Resident 1, they would expect the facility staff to follow the facility's abuse investigation policy to protect the residents from the misappropriation of their property.</p> <p>Reference: (WAC) 388-97-0640 (6)(a)(b)</p>		