STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505478	A. Building B. Wing	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Corwin Center at Emerald Heights	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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 46912 Based on interview and record review, the facility failed to ensure pharmacy services were provided to meet the needs of 1 of 4 residents (Resident 1), reviewed for medication management. The failure to document narcotic (opioid/controlled drugs) medications in accordance with professional standards of practice placed the resident at risk for uncontrolled pain, medication errors, negative outcomes, and a diminished quality of life. Findings included . Review of the facility's policy titled, Administering Medications, revised in April 2013, showed, the individual administering the medication will record in the resident's medical record .the date and time the medication was administered, the dosage, the route of administration .and the signature and title of the person administering the drug. Review of Resident 1's January 2025 Medication Administration Record (MAR) showed an order for oxycodone (a narcotic medication for pain) five milligrams (mg-a unit of measurement) by mouth every four hours for pain, started on 01/28/2025. It further showed no documentation that oxycodone was given to Resident 1 on 01/29/2025 and on 01/30/2025. Review of a nursing progress note written by Staff C, Licensed Practical Nurse, dated 01/29/2025, showed PRN [as needed] medication administered prior to PT [Physical Therapy] and resident tolerated it well. Review of a nursing progress note written by Staff D, Registered Nurse (RN), dated 01/30/2025, showed Resident complained of pain in right arm and requested cold pack and pain medication. PRN Tramadol [a medication for pain] .was unavailable .Resident has Oxycodone 5 mg PO [by mouth] every 4 hours as needed for pain available in the medication cart. Management gave permission to the RN to administer 5 mg of Oxycodone for the resident's pain. Review of the narcotic book for the [NAME] Hall Medication Cart, showed documentation of Resident 1's oxycodone order. It further showed that one dose of oxycodone was taken out of the medication cart on 01/29/2025 and on 01/30/2025 for Resident 1. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/26/2025 at 2:15 PM, when asked if they could review the progress note that they wrote for Resident 1 on 01/29/2025, Staff C stated they did not know how to look up a discharged resident's clinical records and asked Staff B, Resident Care Manager, to help them. In an interview and joint record review on 02/26/2025 at 2:22 PM, Staff B, stated that after licensed nurses administered medications to residents, they expected them to document it in the MAR. Joint record review of Resident 1's progress note from 01/29/2025, showed that PRN medication was given. Staff B stated, it doesn't say what was given. Joint record review of Resident 1's January 2025 MAR showed no documentation that an oxycodone was given on 01/29/2025. Staff B stated, I don't see that anything was charted. Might have to look at the narcotic book. Joint record review of the narcotic book for [NAME] Hall Medication Cart, showed that one dose of oxycodone had been signed out from the medication cart on 01/29/2025. Staff B stated that the oxycodone was signed off in the narcotic book and it doesn't look like it got documented in the MAR. Joint record review of Resident 1's progress note from 01/30/2025, showed that oxycodone was administered to Resident 1. Joint record review of Resident 1's January 2025 MAR showed no documentation that oxycodone was given on 01/30/2025. Staff B stated, it should be charted on the MAR. I don't see anything on January 30th [01/30/2025] for oxycodone. In a follow-up interview and joint record review on 02/28/2025 at 9:40 AM, Staff C stated that after they gave medications to residents they would chart on the MAR. Joint record review of the progress note on 01/29/2025, showed that a PRN medication was given to Resident 1. Staff C stated, it was probably oxycodone. Joint review of the narcotic book showed that a dose of oxycodone was taken out on 01/29/2025. Staff C stated they expected this to be charted on the MAR. Joint review of Resident 1's January 2025 MAR showed no documentation of oxycodone given on 01/29/2025. Staff C stated that the oxycodone they gave Resident 1 on 01/29/2025 was not charted and I was probably busy and that it should have been charted on the MAR. In an interview and joint record review on 02/28/2025 at 10:01 AM, Staff A, Director of Nursing, stated that they expected nurses to document administered medications in the MAR. Joint record review of Resident 1's progress notes, showed that PRN medication and/or oxycodone was given to Resident 1 on 01/29/2025 and on 01/30/2025. Staff A stated that they expected the oxycodone to be documented as given in the MAR. Joint record review of Resident 1's January 2025 MAR showed no documentation that oxycodone was given on 01/29/2025 or on 01/30/2025. Staff A stated that it should have been documented on the MAR after the oxycodone was administered. Reference: (WAC) 388-97-1300 (3)(a)