

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 04/11/2025
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49619</p> <p>Based on observation, interview and record review, the facility failed to implement and/or develop comprehensive care plans for 5 of 6 residents (Residents 2, 1, 3, 4 & 5), reviewed for care planning. The failure to implement and develop care plans for risk of elopement placed residents at risk for elopement, unmet care needs, and potential negative outcomes.</p> <p>Findings included .</p> <p>Review of the facility's policy titled, Elopement and Wandering, Risk of, revised in February 2020, showed, It is the policy of the [Facility name] to ensure that residents who exhibit wandering behavior and/or are at risk of elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk.</p> <p>Review of the facility's policy titled, Care Planning - Interdisciplinary Team, revised in November 2011, showed, Each care plan is individualized to support the resident's medical concerns with interventions and reevaluating dates.</p> <p>Review of the facility's policy titled, [Facility name] Resident Alarms, reviewed on 04/2025, showed When alarms are utilized, additional monitoring shall be provided, including but not limited to: i. Verifying alarms are used in accordance with the resident's care plan. ii. Verifying alarms are working properly .</p> <p>RESIDENT 2</p> <p>Resident 2 admitted to the facility on [DATE].</p> <p>Review of Resident 2's Elopement Risk Evaluation dated 12/19/2024, showed the resident scored a 16 indicating that they were at risk of elopement.</p> <p>Review of Resident 2's comprehensive care plan initiated on 01/03/2023, showed an inappropriate behavior of wandering care plan. It further showed an intervention for WanderGuard [a system in which a resident at risk for elopement/wanderer wears a bracelet, sensors that monitor doors, and alarm in real time] placed on R [right] back of w/c [wheelchair], check placement q [every] shift; check function weekly and as needed.</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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 2's physician orders printed on 04/11/2025 showed no monitoring that the care plan elopement risk intervention was being implemented. There were no physician orders to check for Resident 2's wanderguard placement and function prior to 04/11/2025.</p> <p>On 04/11/2025 at 2:16 PM, Staff H, Nursing Assistant Certified, stated they were employed full time [since October 2024] and had worked on the Aspen Unit of the facility. When asked which residents were at risk for elopement on their unit, Staff H stated Residents 2, 3 and 4. Staff H stated that Resident 2 had dementia (memory loss), wandered around, and did not have a wanderguard. Staff H further stated there would be a care plan for a resident at risk of elopement.</p> <p>Joint observation and interview on 04/11/2025 at 2:37 PM with Staff H, showed Resident 2 did have a wanderguard to the back of their wheelchair. Staff H stated they were unaware that Resident 2 had a wanderguard and was something staff should be aware of.</p> <p>In an interview on 04/11/2025 at 2:57 PM, Staff I, Registered Nurse (RN), stated the process for wanderguard was to have a consent and have orders to check placement and function and that the NACs also checked for wanderguard placement. Staff I stated this was important because staff could hear the wanderguard alarms if functioning properly and stop or prevent the resident from leaving or getting injured. Staff I stated that they were not sure if Resident 2 was at risk of elopement or had a wanderguard.</p> <p>In an interview on 04/11/2025 at 4:00 PM, Staff A, Director of Nursing, stated that there were no [physician] orders to check for Resident 2's wanderguard placement and function prior to 04/11/2025, and that there should have been.</p> <p>RESIDENT 1</p> <p>Review of Resident 1's undated face sheet showed they admitted to the facility on [DATE].</p> <p>Review of Resident 1's Elopement Risk Evaluation dated 12/23/2024, showed that the resident scored a 10 indicating they were at risk of elopement.</p> <p>Review of Resident 1's comprehensive care plan printed on 04/07/2025 (at 12:09 PM) showed no [at risk for] elopement care plan.</p> <p>RESIDENT 3</p> <p>Resident 3 admitted to the facility on [DATE].</p> <p>Review of Resident 3's Elopement Risk Evaluation dated 09/19/2024, showed the resident scored a 20 indicating that they were at risk of elopement.</p> <p>Review of Resident 3's comprehensive care plan printed on 04/11/2025 showed an [at risk for] elopement care plan was initiated on 04/09/2025.</p> <p>RESIDENT 4</p> <p>Resident 4 admitted to the facility on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 4's Elopement Risk Evaluation dated 12/26/2024, showed the resident scored a 14 indicating that they were at risk of elopement.</p> <p>Review of Resident 4's comprehensive care plan printed on 04/11/2025 showed an [known/history of] elopement care plan was initiated on 04/09/2025.</p> <p>RESIDENT 5</p> <p>Resident 5 admitted to the facility on [DATE].</p> <p>Review of Resident 5's Elopement Risk Evaluation dated 12/12/2024, showed the resident scored a 12 indicating that they were at risk of elopement.</p> <p>Review of Resident 5's comprehensive care plan printed on 04/07/2025 showed no [at risk for] elopement care plan.</p> <p>On 04/11/2025 at 2:41 PM, Staff H, stated Resident 5 was not at risk for elopement. Staff H further stated that Resident 5 had dementia and was able to propel themselves in their wheelchair.</p> <p>On 04/07/2025 at 1:09 PM, Staff E, Licensed Practical Nurse, stated that if a resident was at risk of elopement there would be a care plan in place.</p> <p>On 04/07/2025 at 3:15 PM, Staff A stated that they would expect there to be a care plan for a resident who was at risk of elopement or had eloped.</p> <p>On 04/07/2025 at 4:13 PM, Staff D, RN, stated that if a resident was at risk for elopement there should be a care plan.</p> <p>On 04/07/2025 at 4:51 PM, Staff B, Charge Nurse, stated that if a resident was at risk for elopement they would expect it to be somewhere in the care plan.</p> <p>In an interview and joint record review on 04/11/2025 at 2:44 PM, Staff I stated one of the ways they would know a resident was as risk of elopement was by their care plan. Joint record review of Resident 5's care plan showed an [at risk for] elopement care plan initiated on 4/10/2025. Joint record review of Resident 3's care plan showed an [at risk for] elopement care plan initiated on 04/09/2025. Staff I stated there should have been an elopement care plan initiated prior [to 04/09/2025 and 04/10/2025] for Resident 5 and Resident 3.</p> <p>In a follow-up interview on 04/11/2025 at 3:50 PM, Staff A stated that Resident 2 had [physician] orders to check monitoring and placement of their wanderguard as of today [04/11/2025], and would have expected there to have been orders prior. Staff A stated Resident 1 and Resident 5 did not have an elopement care plan before, and now they have. Staff A stated Resident 3 and Resident 4 had elopement care plans initiated on 04/09/2025 and that they should have been initiated prior. Staff A further stated that it was important to have an elopement care plan and monitoring of a wanderguard through orders, so that everyone is aware, that they were at risk and staff could ensure the wanderguard was functioning properly and still in place.</p> <p>Reference: (WAC) 388-97-1020(1), (2)(a)(b)</p>

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49619</p> <p>Based on observation, interview, and record review, the facility failed to provide adequate supervision for 1 of 1 resident (Resident 1), and failed to accurately assess, identify and/or monitor residents at risk of elopement for 5 of 6 residents (Residents 1, 5, 2, 3 & 4), reviewed for accident hazards. Resident 1 experienced harm when they exited the facility unsupervised, was subsequently found by a bystander outside the facility lying on the ground and sustained a significant injury requiring a hospital admission. This failed practice placed the residents at risk for elopement, falls, and injury.</p> <p>Findings included .</p> <p>Review of the facility's policy titled, Elopement and Wandering, Risk of, revised in February 2020, showed, It is the policy of the [Facility name] to ensure that residents who exhibit wandering behavior and/or are at risk of elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. The policy showed, The facility is equipped with door locks/alarms to help avoid elopements. It showed, The facility shall establish and utilize a systemic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. The policy further showed residents would be assessed for risk of elopement and unsafe wandering upon admission, quarterly, as needed, and adequate supervision will be provided to help prevent accidents or elopements.</p> <p>Review of the facility's policy titled, Incidents and Accidents- [Facility name], reviewed on 04/08/2025, showed, It is the policy of this facility for staff to report, investigate, and review any accidents or incidents that occur or allegedly occur, on facility property and may involve or allegedly involve a resident. The policy further showed, The purpose of incident reporting can include: Assuring that appropriate and immediate interventions are implemented and corrective actions are taken to prevent recurrences and improve the management of resident care.</p> <p>Review of the facility's policy titled, Elopement/Missing Person, revised in February 2016, showed, Staff shall promptly report any resident who tries to leave the premises or is suspected of being missing to the License Nurse, Social worker, Assistant DON [or DNS-Director of Nursing] and or Director of Nursing. The policy further showed, When a departing individual returns to the facility, the Director of Nursing Services or designee shall: . n. Ensure Elopement Book is current.</p> <p>ELOPEMENT THAT RESULTED IN A FRACTURE</p> <p>RESIDENT 1</p> <p>Review of Resident 1's undated face sheet showed they admitted to the facility on [DATE] with diagnoses that included the following:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-adjustment disorder with depressed mood (characterized by feelings of sadness, hopelessness, and a lack of enjoyment),</p> <p>-primary insomnia (sleep disorder characterized by difficulty falling asleep, staying asleep, or experiencing poor sleep quality),</p> <p>-depression (serious mood disorder of persistent sadness that affects how you feel, think, and behave),</p> <p>-unspecified moderate dementia (memory loss) with mood disturbance (significant cognitive impairment impacting ability to perform basic daily activities with changes in emotional state),</p> <p>-repeated falls,</p> <p>-anxiety disorder (feelings of excessive worry, fear, and other physical and behavioral symptoms that interfere with daily life) and</p> <p>-unsteadiness on feet.</p> <p>Review of Resident 1's Elopement Risk Evaluation dated 12/23/2024, showed the resident scored a 10 indicating that they were at risk of elopement. The elopement risk evaluation form further showed the CLINICAL AREA [#] 7. Diseases (dementia, any type of mental illness), were blank (if the resident had 2 or more present diagnoses an additional 4 points would have been added to the score).</p> <p>Review of Resident 1's Falls Risk Evaluation dated 12/23/2024, showed the resident scored a 13 indicating that they were a high risk for falls. An additional Falls Risk Evaluation dated 03/05/2024, showed the resident scored a 13 indicating that they were at a high risk for falls.</p> <p>Review of Resident 1's comprehensive care plan printed on 04/07/2025 (at 12:09 PM) showed no [at risk for] elopement care plan.</p> <p>Review of Resident 1's falls care plan printed on 04/07/2025 (at 12:09 PM) showed Resident 1 was at risk for falls due to history of falls, generalized weakness, and dementia with poor safety awareness and impulsiveness.</p> <p>Review of Resident 1's nursing progress note event dated 03/30/2025, showed Resident was awake and alert throughout shift. She was wheeling around the unit and was found by NAC [Nursing Assistant Certified] near mailboxes outside of [the] [Facility Name] Hallways. Resident was redirected to her room and told to remain on unit for her safety. Note made to further discuss wanderguard [a system in which a resident at risk for elopement/wanderer wears a bracelet, sensors that monitor doors, and alarm in real time] with RCM [Resident Care Manager] as resident has a [sic] Hx [history] of exploring.</p> <p>Review of Resident 1's nursing progress note event dated 03/31/2025, showed Resident awake the entire [sic] [NOC-night] shift, was up in wheelchair, self-propelling constantly in the unit due to [sic] complaint of insomnia, no exit seeking noted [signed at 7:43 AM by Staff J, Registered Nurse (RN)].</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 1's nursing progress note event dated 03/31/2025, showed Resident was wandering unit in WC [wheelchair] throughout entire [evening] shift. Continuously had to be redirected away from doors and taken out of rooms of other residents. Wanderguard for her safety to be further discussed with RCM and DPOA [Durable Power of Attorney] [signed on 04/01/2025 at 1:04 AM by Staff D, RN].</p> <p>Review of Resident 1's nursing progress note event dated 04/01/2025, showed at 10:40 PM, a [unknown] staff member had requested an Uber ride. The note showed, The Uber driver informed the security guard [about a resident [Resident 1] on the ground], who subsequently called 911. It showed that a staff member informed the nurse that Resident 1 had fallen outside of the facility. The note further showed that staff found Resident 1 on the curbside concrete, having tipped over in a wheelchair with the right side rail removed. Right arm and wrist bleeding were observed. The [City] Fire Department Medic was already present to transport the individual [resident] to the emergency room for further evaluation.</p> <p>Review of Resident 1's Hospital emergency room note dated 04/01/2025 (at 11:29 PM) showed, a Bystander found patient [the resident] down outside the facility and called 911. Patient is confused, oriented to self only and states she was out driving tonight. Staff came out once aid car arrived and identified the patient as their resident.</p> <p>Review of Resident 1's Hospital Discharge Summary dated 04/07/2025 showed Resident 1's discharge diagnosis included an unwitnessed ground-level fall, right elbow fracture (broken bone), and moderate dementia. It further showed Resident 1 was found to have an elbow laceration [cut] with an olecranon [bony tip of the elbow] fracture, as well as volume depletion [reduction in fluid or dehydration] with mildly elevated CK [Creatine Kinase-may indicate recent muscle trauma or strenuous exercise].</p> <p>Observation and interview on 04/07/2025 at 2:24 PM, showed Resident 1 was lying in bed with a bandage around their right arm/elbow area and a wanderguard to their left wrist. Resident 1 stated they fell and broke an elbow.</p> <p>Observation on 04/08/2025 at 2:20 PM, showed an unknown [therapy] staff was working with Resident 1. Resident 1 stated, I think I want to travel a little bit further and see what's going on at the big house. Staff advised resident to stay in their room as they were on precautions.</p> <p>Observation on 04/11/2025 at 1:52 PM, showed Resident 1 was self-propelling in their wheelchair down the hallway.</p> <p>On 04/07/2025 at 12:25 PM, Staff G, NAC, stated that Resident 1 was able to propel themselves in their wheelchair and that Resident 1 did a lot of things on her own, and would refuse assistance from staff at times.</p> <p>On 04/07/2025 at 1:09 PM, Staff E, Licensed Practical Nurse (LPN), stated Resident 1 had somehow got outside, and fell from their wheelchair and had a fracture. Staff E stated that Resident 1 wandered and self-propelled themselves in their wheelchair but had not witnessed them exit seeking.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview and joint record review on 04/07/2025 at 3:15 PM, Staff A, DNS, stated residents were assessed for risk of elopement upon admission using their Elopement Risk Evaluation. Staff A stated that if a resident was at risk for elopement, they would expect the resident to be identified in their Elopement/Wander Risk Book and in their care plan. Joint record review of Resident 1's Elopement Risk Evaluation dated 12/23/2024, showed Resident 1 scored a 10, Staff A stated that according to their assessment Resident 1 was at risk for elopement and the intervention that was put in place was diversion-distraction. Staff A stated that Resident 1 was able to propel themselves in their wheelchair. Staff A stated that on 03/31/2025 Resident 1 exited the Center/facility into a common and safe area that was not considered a part of their Center. Staff A stated that there was access to exit doors where Resident 1 had been found, and that they would say the area was safe but, the fact that it does have exit doors is a concern. Staff A further stated that they were not personally informed that Resident 1 had left the Center on 03/31/2025, or that they possibly needed a wanderguard. Staff A stated that on 04/01/2025, Resident 1 had a fall and was on neuro checks. Staff A stated that later that day at 10:40 PM, a staff member had called for an Uber ride, and that when they arrived the Uber driver informed them that someone had fallen and that they informed the guardhouse. Staff A stated that the staff member went back into the facility to let the nurse know that Resident 1 had fallen off the sidewalk out of their wheelchair and landed on their right side.</p> <p>A joint observation and interview on 04/07/2025 at 3:48 PM, Staff A showed a metal door at the end of Cedar Hallway that was not locked/alarmed. Staff A stated that Resident 1 took this route to go outside of the facility when they eloped on 04/01/2025. Staff A stated that this door was alarmed with residents who used a wanderguard.</p> <p>In another interview on 04/07/2025 at 3:57 PM, Staff A stated that when Resident 1 eloped and fell on [DATE], it was an avoidable accident. When asked if Resident 1 obtained any harm from the elopement incident on 04/01/2025, Staff A stated, she fell and broke her arm. Staff A stated that Staff D could have verbally informed management when Resident 1 had left the Center on 03/31/2025 and was found near the mailboxes and they could have put another intervention in place. Staff A stated that they had not reviewed the progress notes for Resident 1, and that their expectation was for progress notes to be reviewed daily in their clinical meeting. Staff A stated that they could have increased supervision, highly considered to have a wanderguard, or done 15 or 30 minute checks, and did not need consent for these frequent checks. Staff A further stated they would have expected these frequent checks to be in place following Resident 1 exiting the Center on 03/31/2025.</p> <p>On 04/07/2025 at 4:13 PM, Staff D stated that they worked with Resident 1 on evening shift on 03/30/2025 and 03/31/2025. Staff D stated that on 03/30/2025, Resident 1 was just wheeling around, and that on 03/31/2025 Resident 1 was found near the mailboxes outside of the Center by staff and she was brought back. Staff D stated that Resident 1 should not have been left unsupervised as she was at risk for elopement. Staff D stated that further down the hall near the mailboxes where Resident 1 was found, there was the main entrance with access to exit doors. Staff D stated that they stopped Resident 1 on multiple occasions as they opened doors and redirected them in the Center. Staff D stated that it was very clear that Resident 1 was going to all the doors. Staff D stated that it was getting to a point to where she was going to exit the facility, and that it became much more apparent, more than likely it was going to happen. Staff D stated that they documented Resident 1's behavior and what had occurred on 03/31/2025 in the progress notes and reported it during shift report with other staff. Staff D stated that they talked with Staff C, RCM, LPN, who told them to report it to Staff B, Charge Nurse. Staff D further stated that they sent Staff B an email informing them about Resident 1's attempts to exit seek and consideration for a wanderguard.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of an email notification dated 04/01/2025 (1:16 AM) showed, Staff D sent an email to Staff B, Staff D stated, I wanted to bring up the potential of getting [Resident 1] a Wanderguard. She has been wandering the unit, entering peoples' rooms, and found by an NAC out by the mailboxes near the concierge. She constantly needs redirection away from the doors throughout the shift and can be difficult to persuade/not always listening when asked to return. I caught her twice today trying to open the Cedar entrance door and once trying to go through the 2 main doors that lead toward the kitchen/laundry exit from Cedar. She agreed to sit in her WC at the entrance just holding the door open, but it took much more convincing to get her to completely leave it alone.</p> <p>In a joint record review and interview on 04/08/2025 at 3:14 PM with Staff K, IT Technician, showed a Delivery Report for Staff D's email sent to Staff B on 04/01/2025 at 1:15 AM. The report further showed, The message was successfully delivered. Staff K stated, What I can tell from this is that the email was successfully delivered on 04/01/2025 at 1:15 AM. If it was placed into a folder that the recipient normally doesn't check like a junk folder, then it could be missed, but in the system it shouldn't have been placed in a different folder because it was sent internally [within the same system].</p> <p>On 04/07/2025 at 4:51 PM, Staff B stated that they had been made aware by Resident 1's Representative that Resident 1 had got out the front and had gone to the hospital. Staff B stated that Resident 1 was unsupervised and found outside of the facility (on 04/01/2025). When asked if Resident 1 had obtained any harm from this incident, Staff B stated, she fractured her elbow. Staff B stated that Resident 1 should not have been left alone or unsupervised outside of the facility. Staff B stated that it was their expectation to review notes as regularly as possible, but did not take documentation in the progress notes as notification. Staff B stated that they did not review the progress notes documented by Staff D until after Resident 1's elopement on 04/01/2025. Staff B stated they did not receive an email from Staff D informing them of Resident 1's attempt to exit or consider for a wanderguard. Staff B further stated, I do think it [elopement incident that occurred on 04/01/2025] was avoidable.</p> <p>On 04/08/2025 at 2:02 PM, Staff C, stated that on the other side of the metal door on Cedar Hallway, it was considered independent living, but sometimes residents of the Center would dine or visit there. Staff C stated that if a resident was at risk for elopement or a high fall risk they should not be left unsupervised and should be accompanied outside of those doors. Staff C stated that they review progress notes with the Charge Nurse, DON, MDS [Minimum Data Set-an assessment tool] Coordinator, and sometimes the Administrator. Staff C stated, I think something happened that we didn't meet, and that this [review of progress notes for Resident 1's [wandering/exit-seeking] behavior on 03/30/2025 to 03/31/2025] didn't get discussed in detail, or we would have caught that. Staff C stated that they were doing something and were interrupted on 03/31/2025 when Staff D came in to report Resident 1's behavior. Staff C stated that they did not have a good recollection of the conversation, but they did know they, passed her [Staff D] off to the appropriate care manager.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Corwin Center at Emerald Heights		STREET ADDRESS, CITY, STATE, ZIP CODE 10901 - 176th Circle Northeast Redmond, WA 98052	
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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>In a follow up interview and joint record review on 04/08/2025 at 3:13 PM with Staff B, stated they expected elopement assessments to be completed and accurate. Joint record review of Resident 1's face sheet printed on 12/23/2024 showed diagnoses that included adjustment disorder with depressed mood, depression, unspecified moderate dementia with mood disturbance and anxiety disorder. Joint record review of Resident 1's Elopement Risk Evaluation dated 12/23/2024, showed clinical area 7. was blank. Staff B stated that the intent was to go back [to complete the evaluation] once all of the diagnoses were entered, but that the appropriate box should have been checked based on the hospital discharge summary. Staff B further stated that Resident 1's elopement score would have increased to 14 based on their diagnoses. Joint record review of Resident 1's Falls Risk Evaluation dated 12/23/2024, showed Resident 1 was a high fall risk. Staff B further stated Resident 1 who was a high fall risk should not have been outside of the Center unsupervised.</p> <p>In a phone interview on 04/11/2025 at 1:56 PM, Staff F, NAC, stated that on 04/01/2025 they finished their evening shift around 10:40 PM, and ordered an Uber ride. Staff F stated that the Uber driver informed them that they had notified the security that there was a lady on the ground, and that they thought they needed help. Staff F stated that they saw Resident 1 laying on the ground with their wheelchair laying sideways and bleeding from her elbow. Staff F stated they quickly went inside the facility to inform the nurse and by the time they went back outside 911 had already arrived. Staff F further stated Resident 1 was always looking for an exit and that most of the time they were in their wheelchair going around the facility. Staff F stated that the metal door at the end of Cedar Hallway did not alarm, unless the resident had a wanderguard and that Resident 1 did not have a wanderguard at the time. Staff F further stated Resident 1 should not have been unsupervised outside of the Center.</p> <p>In a joint record review and interview on 04/11/2025 at 3:55 PM, with Staff A, showed Resident 1's Elopement Risk Evaluation dated 12/23/2024. Staff A stated, she would have at least scored a 4 for question 7, and that it would have increased Resident 1's elopement score to a 14.</p> <p>In another interview and joint record review on 04/11/2025 at 4:10 PM, Staff A stated that Resident 1's fall risk score was a 13 indicating that they were a high fall risk. Staff A stated that Resident 1 had a history of falls. Staff A stated that Resident 1 was at risk of elopement and a high fall risk and should not have been unsupervised when they eloped on 04/01/2025. Staff A further stated that the facility staff was not searching for Resident 1 or were aware that the resident was missing on 04/01/2025, until it was reported by the Uber driver to staff and was found away from the facility Center. Staff A stated that staff outside of the Center were not responsible for Resident 1's safety and that they did not have access to their medical information, and that Resident 1 was the Center staff's responsibility.</p> <p>ACCURATE ASSESSMENTS AND IDENTIFICATION OF ELOPEMENT RISKS</p> <p>RESIDENT 5</p> <p>Review of Resident 5's undated face sheet showed they admitted to the facility on [DATE] with diagnoses that included unspecified moderate dementia with agitation, depression, and anxiety disorder.</p> <p>Review of Resident 5's Elopement Risk Evaluation dated 12/12/2024, showed the resident scored a 12 indicating that they were at risk of elopement. The evaluation further showed that under clinical area, 7. Diseases, 2 was marked [indicating 1 diagnosis was present].</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/11/2025 at 2:41 PM, Staff H, NAC, stated Resident 5 was not at risk for elopement. Staff H further stated that Resident 5 had dementia and was able to propel themselves in their wheelchair.</p> <p>In an interview and joint record review on 04/11/2025 at 3:13 PM, Staff I, RN, stated that Resident 5's elopement score was a 12 meaning that they were at risk for elopement. Joint record review of Resident 5's face sheet showed diagnoses that included unspecified moderate dementia with agitation, depression, and anxiety disorder. Joint record review of the Elopement Risk Evaluation dated 12/12/2024 showed that under clinical area, 7. Diseases, 2 was marked [indicating 1 diagnosis was present]. Staff I stated a 2 or more present [diagnosis] should have been checked instead, increasing Resident 5's elopement score to a 14.</p> <p>In a joint record review and interview on 04/11/2025 at 3:56 PM, with Staff A, showed Resident 5's Elopement Risk Evaluation dated 12/12/2024, elopement score of 12. Staff A stated Resident 5's elopement score should have been 14.</p> <p>RESIDENT 2</p> <p>Review of Resident 2's undated face sheet showed they admitted to the facility on [DATE] with diagnoses that included Alzheimer's Disease (progressive brain disorder that primarily affects memory, thinking, and behavior), anxiety disorder, and unspecified severe dementia with psychotic [a state where an individual loses touch with reality] disturbance.</p> <p>Review of Resident 2's Elopement Risk Evaluation dated 12/19/2024, showed the resident scored a 16 indicating that they were at risk of elopement. The evaluation further showed 7. Diseases, 2 was marked [indicating 1 diagnosis was present].</p> <p>In a joint record review and interview on 04/11/2025 at 2:57 PM with Staff I, showed Resident 2's Elopement Risk Evaluation dated 12/19/2024 showed a score of 16, and an intervention for Wanderguard Bracelet Door Alarm. Staff I stated Resident 2 was at risk for elopement and they thought Resident 2 did not have a wanderguard. Staff I further stated it was important to know that Resident 2 did have a wanderguard, and did not remember documenting in the electronic treatment administration record if they had one. Staff I stated that Resident 2's Elopement Risk Evaluation dated 12/19/2024 was incorrect as Resident 2 had more than one diagnosis for dementia or mental illness present. Staff I stated that 2 or more [diagnosis] present, should have been checked instead of increasing Resident 2's elopement score.</p> <p>In a joint record review and interview on 04/11/2025 at 4:00 PM with Staff A, showed Resident 2's Elopement Risk Evaluation dated 12/19/2024, revealed the resident scored a 16 indicating that they were at risk of elopement. The evaluation further showed 7. Diseases, 2 was marked [indicating 1 diagnosis was present]. Staff A stated that it should have been a 2 or more present and that a new Elopement Risk Evaluation had been completed, and Resident 2 had an updated score of 22.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>In a follow-up interview and joint record review on 04/11/2025 at 3:50 PM, Staff A stated their expectation was for the Elopement Risk Evaluations to be complete and accurate. Staff A stated their expectation was for these assessments to be completed upon admission, quarterly, or with any changes. Joint record review of the Elopement/Wander Risk Book Index Page 1 and 2 dated 04/02/2025, showed Resident 1, 2, and 5 were not identified as being at risk of wandering/elopement. Staff A stated that social services were responsible for the Elopement/Wander Risk Book and expected residents that were at risk for elopement or had a known history of wandering be identified in the book. Staff A stated they did not know the reason why Residents 1, 2, and 5 were not in the book, but did know that they were on a list they sent to social services yesterday (04/10/2025) to update and would have expected these residents to already have been in the book.</p> <p>MONITORING RESIDENTS AT RISK FOR ELOPEMENT</p> <p>Review of the facility's policy titled, [Facility name] Resident Alarms, reviewed 04/2025, showed When alarms are utilized, additional monitoring shall be provided, including but not limited to: i. Verifying alarms are used in accordance with the resident's care plan. ii. Verifying alarms are working properly .</p> <p>Review of Resident 2's physician orders printed on 04/11/2025 showed no monitoring for elopement risk intervention.</p> <p>On 04/11/2025 at 2:16 PM, Staff H stated they were employed full time and had worked on the Aspen Unit of the facility. When asked which residents were at risk for elopement on their unit, Staff H stated Resident 2, 3 and 4. Staff H stated that Resident 2 had dementia, wandered around, and did not have a wanderguard.</p> <p>Joint observation and interview on 04/11/2025 at 2:37 PM with Staff H, showed Resident 2 did have a wanderguard to the back of their wheelchair. Staff H stated they were unaware that Resident 2 had a wanderguard and was something staff should be aware of.</p> <p>In an interview on 04/11/2025 at 2:57 PM, Staff I stated the process for wanderguard was to have a consent and have orders to check placement and function. Staff I stated this was important because staff could hear the wanderguard alarms if functioning properly and stop or prevent the resident from leaving or getting injured stating because most of the time when they escape they can get injured. Staff I stated that they were not sure if Resident 2 was at risk of elopement or had a wanderguard.</p> <p>In an interview on 04/11/2025 at 4:00 PM, Staff A stated that there were no [physician] orders to check for Resident 2's wanderguard placement and function prior to 04/11/2025, and that there should have been.</p> <p>RESIDENT 3</p> <p>Resident 3 admitted to the facility on [DATE].</p> <p>Review of Resident 3's Elopement Risk Evaluation dated 09/19/2024, showed the resident scored a 20 indicating that they were at risk of elopement. The evaluation further showed an intervention for Diversion-Distraction and Wanderguard Bracelet Door Alarm, were checked off.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 3's physician orders printed on 04/11/2025, showed no monitoring for elopement risk intervention prior to 04/10/2025 [the resident was identified as at risk for elopement based on the 09/19/2024 elopement risk evaluation].</p> <p>In a joint record review and interview on 04/11/2025 at 4:09 PM with Staff A, Resident 3 had physician orders to check for placement and function for wanderguard. Staff A stated that the wanderguard orders were initiated on 04/10/2025 and that they should have been in place prior to that as the resident was at risk for elopement since 09/19/2024.</p> <p>RESIDENT 4</p> <p>Resident 4 admitted to the facility on [DATE].</p> <p>Review of Resident 4's Elopement Risk Evaluation dated 12/26/2024, showed the resident scored a 14 indicating that they were at risk of elopement. The evaluation further showed an intervention for Wanderguard Bracelet Door Alarm, was checked off.</p> <p>Review of Resident 4's physician orders printed on 04/11/2025 showed no monitoring for elopement risk intervention prior to 04/10/2025 [the resident was identified as at risk for elopement based on the 12/26/2024 elopement risk evaluation].</p> <p>In an interview on 04/11/2025 at 2:19 PM, Staff H stated Resident 4 had a wanderguard on their wheelchair and that they always [everyday] attempted to open doors or tried to use the elevator by themselves.</p> <p>In an interview and joint record review on 04/11/2025 at 2:50 PM, Staff I stated that Resident 4 was at risk of elopement. Staff I stated that Resident 4 tried to go to the elevator, or to door or window at the end of the Aspen hallway. Staff I stated Resident 4 had a wanderguard. Joint record review of Resident 4's physician orders showed an order to check placement and function of the wanderguard dated 04/11/2025. Staff I stated Resident 4 should have had orders when the wanderguard was first initiated.</p> <p>In an interview and joint record review on 04/11/2025 at 3:50 PM, Staff A stated that their expectation was for orders to check placement and function of wanderguard to be in place, to ensure that they were functioning. Joint record review of Resident 4's physician orders showed physician orders to check for placement and function of Resident 4's wanderguard. Staff A stated that they were initiated on 04/10/2025 and that it should have been in place prior as Resident 4 had a wanderguard since 12/26/2024.</p> <p>Reference: (WAC) 388-97-1060 (3)(g)</p>		