

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/19/2013
FORM APPROVED
OMB NO. 0938-0391

862

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505452	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/13/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MESSENGER HOUSE CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 10861 NE MANITOU PARK BLVD BAINBRIDGE ISLAND, WA 98110
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Off-Hours Quality Indicator Survey conducted at Messenger House Care Center on 2/6/13, 2/7/13, 2/8/13, 2/11/13, 2/12/13, and 2/13/13. The survey included data collection on Friday 2/8/13 between 4:30 a.m. and 10:30 a.m. A sample of 36 residents was selected from a census of 74. The sample included 32 current residents and the record of 4 discharged residents.</p> <p>The survey was conducted by:</p> <p>██████████ RN, BSN, MBA ██████████ RN, BSN, MSN ██████████ RN, BSN, MN</p> <p>The survey team is from:</p> <p>Department of Social and Health Services Aging and Disability Services Administration Residential Care Services, District 3, Unit A 1949 South State Street, MS: N27-24 Tacoma, Washington, 98405-2850</p> <p>Telephone: (253) 983-3800 Fax: (253) 589-7240</p> <p><i>[Signature]</i> Signature</p> <p>2/19/13 Date</p>	F 000	<p>RECEIVED PAR 00 REC'D RECEIVED PAR 07 REC'D LISES - ADISA RCS - REGION 6</p>	
-------	--	-------	---	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X6) DATE 3/5/13
---	----------------------------	-------------------------

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505452	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/13/2013
NAME OF PROVIDER OR SUPPLIER MESSENGER HOUSE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 10861 NE MANITOU PARK BLVD BAINBRIDGE ISLAND, WA 98110		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	Continued From page 1	F 000	The following written allegation of compliance is intended to meet the requirements for a plan of correction under state and federal law and is not an admission that the survey findings are correct or that they rise to the level of deficiencies under applicable law.		
F 156 SS=D	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p>	F 156	<p>Resident #68 has discharged from the facility.</p> <p>For residents currently receiving Medicare benefits, the facility has in place a system to notify personnel responsible for issuing either an ABN or NOMNC to applicable residents as required. The same system will apply for notification of future residents receiving Medicare benefits.</p> <p>Routine admissions meetings are held where planned discharges and scheduled first non-covered day for Medicare beneficiaries / discontinuation of Medicare services are reviewed.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505452	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/13/2013
NAME OF PROVIDER OR SUPPLIER MESSENGER HOUSE CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 10861 NE MANITOU PARK BLVD BAINBRIDGE ISLAND, WA 98110		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	<p>Continued From page 2</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's</p>	F 156	<p>The facilities administrative QI team will monitor for ongoing compliance.</p> <p>The facility's Administrator will be responsible to monitor for correction.</p>	3/8/13

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505452	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/13/2013
NAME OF PROVIDER OR SUPPLIER MESSENGER HOUSE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 10861 NE MANITOU PARK BLVD BAINBRIDGE ISLAND, WA 98110		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 156	<p>Continued From page 3</p> <p>option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to inform 1 of 3 Sampled Residents (#68) when Medicare Skilled Services would end out of the 36 sampled residents who were included in the Stage 2 review. This prevented the resident from having the opportunity to appeal termination of Medicare services.</p> <p>Findings include:</p> <p>On 2/12/13 Staff C provided information that identified Resident #68 admitted to the facility on [REDACTED] 12 with Medicare coverage and had 55 Medicare days remaining when discharged on [REDACTED] 12.</p> <p>Nursing notes dated 10/1/12 documented the</p>	F 156			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505452	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/13/2013
NAME OF PROVIDER OR SUPPLIER MESSENGER HOUSE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 10861 NE MANITOU PARK BLVD BAINBRIDGE ISLAND, WA 98110		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 156	<p>Continued From page 4</p> <p>resident saw a physician outside the facility and had a specialized intravenous line removed used previously for treatments. Notes identified the resident returned to the facility later in the evening.</p> <p>Additional nursing notes dated 10/2/12 identified at 10:30 a.m., the facility held a meeting to discuss Medicare residents. Meeting notes indicated the discharge plan indicated for the resident to discharge home with her husband.</p> <p>A nursing note written later on 10/2/12, timed at 1:00 p.m., documented staff notified the physician earlier that morning the resident wished to be discharged and the specialized intravenous line had been removed. The note documented the resident discharged at 1:15 p.m.</p> <p>On 2/12/13 at 1:17 p.m., Staff C reported he/she did not have an opportunity to provide the resident with the information since the resident left on short notice.</p> <p>On 2/12/13 at 3:22 p.m. Staff B reported the resident was no longer eligible for continued Medicare payment after the intravenous line came out. Staff B also reported when Medicare covered skilled services ended, residents can usually continue to remain a couple of days in the facility to prepare for discharge and do not have to discharge immediately. Staff B confirmed the resident would have received and signed discharge paperwork before leaving the facility.</p> <p>The resident's record did not contain evidence the facility informed Resident #68 in writing after staff held the Medicare meeting on 10/2/12 and</p>	F 156			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505452	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/13/2013
NAME OF PROVIDER OR SUPPLIER MESSENGER HOUSE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 10861 NE MANITOU PARK BLVD BAINBRIDGE ISLAND, WA 98110		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 156	Continued From page 5 before discharge when Medicare coverage would actually be discontinued or if the resident understood she did not have to discharge immediately and had the right to appeal the decision to terminate Medicare coverage.	F 156			
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to provide care and services in a manner that promoted and protected resident dignity during dining for 1 Sampled Resident (#59) in 1 of 3 Dining Rooms (400 Unit). This failure placed the resident at risk for diminished quality of life. Findings Include: Resident #59 was admitted to the facility on [REDACTED] 09 with multiple diagnoses to include [REDACTED] ([REDACTED] of the [REDACTED]) and [REDACTED]. On 2/6/13 between 1:15 p.m. to 1:35 p.m. resident #59 was seated in a chair by herself with a table in front. The lower area of the table came in contact with her knees, and the table was positioned some distance from the resident. Due to the resident's [REDACTED], she leaned forward the entire time. The resident used a spoon in the right	F 241	F 241 Resident #59 has been provided per Occupational Therapy staff an adjustable table which enables her to sit with her legs appropriately under the table. The adjustable table fits over residents lap reducing food spillage with decrease of bending to pick up items off the floor. Residents will be reviewed after admission and as needed for appropriate dining room equipment needs which help promote dignity while eating meals in the dining room. Table positioning/needs will be followed at meals with routine observations per Unit Manager or designee for ongoing compliance. The facility's DNS will be responsible to monitor for correction.	2/19/13	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505452	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/13/2013	
NAME OF PROVIDER OR SUPPLIER MESSENGER HOUSE CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 10861 NE MANITOU PARK BLVD BAINBRIDGE ISLAND, WA 98110		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	<p>Continued From page 6</p> <p>hand to eat pureed food. Twice while putting a spoon into 3 different glasses on the table, she brought the liquids up to her mouth and dropped a few drops of liquids onto her right pant leg.</p> <p>On 2/8/13 during dining observation at 8:50 a.m., Resident #59 was assisted by unidentified staff members to a chair to eat at a small table to accommodate her height and medical condition. The small table had an extra piece of decorative wood underneath. This extra piece of wood prevented the table from going over the residents legs which would have allowed her to sit closer to the table. Instead, the wood piece under the table created a space of approximately 10 inches between the resident and the table.</p> <p>During dining the resident proceeded to scoop food onto an eating utensil, and when she attempted to place the food into her mouth; the food fell off the eating utensil onto her clothing and onto the floor before reaching her mouth. The resident proceeded to pick the food up from the floor with her fingers, placed the food in her mouth, and ate the food which had fallen onto the floor.</p> <p>On 2/8/13 at 9:06 a.m., Staff N reported that the resident could not sit close to the table, because the "lip" under the table would not allow the table to be placed over her lap without hitting her knees.</p> <p>Failure to provide a table to accommodate the resident's needs, placed the resident at risk for diminished quality of life. Refer to F464 for failure to provide adequate dining furnishings.</p>	F 241		
F 280	483.20(d)(3), 483.10(k)(2) RIGHT TO	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505452	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/13/2013	
NAME OF PROVIDER OR SUPPLIER MESSENGER HOUSE CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 10861 NE MANITOU PARK BLVD BAINBRIDGE ISLAND, WA 98110		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280 SS=D	<p>Continued From page 7</p> <p>PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interview and record review, it was determined that the facility failed to revise the care plan for 1 of 3 Sampled Residents (#3) reviewed for vision of the 36 residents included in the Stage 2 review to ensure Resident #3 had a visual examination to rule out the need for corrective lenses. This failure placed Resident #3 at risk for a less than optimal visual quality of life.</p> <p>Findings include:</p>	F 280 F 280	<p>Resident #3's care plan has been updated to include optometrist/vision services with DPOA consent. Resident will be seen per the Optometrist with the next scheduled visit within the facility. Optometry services/vision services will be provided per the Optometrist recommendation and PRN.</p> <p>To avoid similar situations with current and future residents, resident care plans have and will continue to be updated to include visual services as needed with resident or DPOA consent.</p> <p>Visual services guidelines have been updated to provide follow-up /review of residents visual services minimally on an annual basis or as needed when the resident or their representative has declined visual services in the past.</p> <p>Social Services Director will audit the visual services log routinely for compliance.</p> <p>The facility's DNS will be responsible to monitor for correction.</p>	3/8/13

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505452	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/13/2013
NAME OF PROVIDER OR SUPPLIER MESSENGER HOUSE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 10861 NE MANITOU PARK BLVD BAINBRIDGE ISLAND, WA 98110		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 280	<p>Continued From page 8</p> <p>Resident #3's comprehensive Minimum Data Set (MDS) dated 8/24/12 assessed the resident as having adequate vision and no corrective lenses. Two subsequent quarterly MDS assessments dated 11/9/12 and 1/20/13 assessed the resident as having moderately impaired vision with no corrective lenses.</p> <p>Resident #3's current "In-Room Directives", containing directives used by the nursing assistants to provide care identified the resident had impaired vision.</p> <p>The resident's current care plan had an activity of daily living goal to accept objects handed to him/her without squinting.</p> <p>On 2/8/13 at 8:49 a.m., on 2/11/13 at 2:15 p.m. and at 2:50 p.m. and on 2/12/13 at 6:48 a.m. and at 7:57 a.m. Resident #3, with cognitive impairments, was not wearing glasses.</p> <p>On 2/11/13 at 2:15 p.m. Resident #3 told the surveyor she needed glasses to see.</p> <p>Record review noted Resident #3 had not had a visual exam to determine if she/he could participate in the exam to determine the need for corrective lenses (glasses).</p> <p>On 2/11/13 at 2:06 p.m. Staff R, who completes the minimum data assessments, reported no knowledge of Resident #3 having glasses.</p> <p>On 2/11/13 at 2:25 p.m. Staff S reported on 10/7/11 Resident #3's surrogate decision maker signed a consent on 10/7/11 for the resident not to have vision services.</p>	F 280			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505452	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/13/2013	
NAME OF PROVIDER OR SUPPLIER MESSENGER HOUSE CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 10861 NE MANITOU PARK BLVD BAINBRIDGE ISLAND, WA 98110		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 9 On 2/12/13 at 8:03 a.m. Staff S reported Resident #3 does not have glasses and was not admitted with glasses. Staff S agreed the resident had not been evaluated by an eye doctor. Resident #3 had two quarterly MDS assessment dated 11/9/12 and 1/20/13 which assessed the resident as having moderately impaired vision with no corrective lenses which was a change from the resident's MDS dated 8/24/12. The facility failed to revise the resident's care plan by failing to contact the resident's surrogate decision maker to discuss having a physician evaluate Resident #3 to determine if the resident could participate in a visual examination to rule out whether or not the resident would benefit from the use of corrective lenses.	F 280		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to consistently follow physician orders for monitoring monthly orthostatic blood pressures for 6 of 10 Sampled Residents (#s 1, 16, 18, 33, 48, 78), reviewed for medication use of the 36 sampled residents who were included in the Stage 2 review. Failure to follow physician orders for medication monitoring had the potential to place residents at risk for staff to not identify if adverse side effects	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505452	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/13/2013	
NAME OF PROVIDER OR SUPPLIER MESSENGER HOUSE CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 10861 NE MANITOU PARK BLVD BAINBRIDGE ISLAND, WA 98110		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	<p>Continued From page 10 developed.</p> <p>Findings include:</p> <p>According to Lippincott Manual of Nursing Practice , ninth edition, (Lippincott, Williams & Wilkins), page 17, states "Departure from Standards of Care" includes "Failure to implement a physician's, advanced practice nurse's or physician assistant's order properly or in a timely fashion."</p> <p>Refer to F 329 for additional explanations regarding orthostatic blood pressures (postural blood pressures), resident observations, medication use and medical histories for Resident (#s 1,16, 18, 33, 48 & 78).</p> <p>RESIDENT #16 February 2013 physician orders included an order dated 5/9/12 for staff to check Resident #16's postural blood pressures monthly.</p> <p>Staff failed to follow physician orders and obtain the resident's postural blood pressures as ordered during November 2012 and December 2012.</p> <p>RESIDENT #33 February 2013 physician orders identified on 10/24/12 the physician directed staff to check Resident #3's orthostatic blood pressures monthly.</p> <p>Medication Administration Records for November 2012, December 2012 and January 2012 contained directions for staff to check orthostatic blood pressures but did not contain evidence staff</p>	F 281	<p>F 281 Residents #1, 16, 18, 33, 48 and 78 have had their postural blood pressures completed for February 2013 per current Physician orders. Documentation of February postural blood pressures has been placed on the individual residents MAR (Medication Administration Record).</p> <p>Postural blood pressure guidelines have been developed and reviewed in accordance with the Medical Director Dr. Sabrina Benjamin's instruction.</p> <p>Licensed staff have been re-educated on facility guidelines for postural blood pressures related to antipsychotic or antidepressant medications.</p> <p>Compliance with postural blood pressure guideline related to antipsychotic/antidepressant medications will be followed with routine medication administration records audits per DNS or designee.</p> <p>The facility's Unit Manager and DNS will be responsible to monitor for continued correction.</p>	3/8/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505452	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/13/2013	
NAME OF PROVIDER OR SUPPLIER MESSENGER HOUSE CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 10861 NE MANITOU PARK BLVD BAINBRIDGE ISLAND, WA 98110		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	<p>Continued From page 11</p> <p>obtained the blood pressures as ordered.</p> <p>On 2/13/13 at 8:48 a.m. Staff E reported medical records marked medication records for staff to check monthly orthostatic blood pressures on a specific day. If nursing staff did not see it completed and it is left blank, then it should be done the next day.</p> <p>On 2/13/12 at 9:26 a.m. Staff B confirmed Resident #33's monthly orthostatic blood pressures had not been done.</p> <p>RESIDENT #78 Resident #78 was admitted to the facility on [REDACTED] 12 and had multiple diagnoses to include [REDACTED] state and [REDACTED].</p> <p>Record review revealed the resident was taking medication to include [REDACTED] a (an [REDACTED] drug) and [REDACTED] (an [REDACTED] drug). Further review of the record revealed a physician order dated 10/24/12 that orthostatic blood pressures were to be done monthly related to [REDACTED] medication use. Record review revealed orthostatic blood pressures were not done for the months of November 2012 and December 2012.</p> <p>On 2/12/13 at 7:36 a.m., Staff D confirmed orthostatic blood pressures were not done for the months of November 2012 and December 2012.</p> <p>RESIDENT #18 Resident #18 was admitted to the facility on [REDACTED] 11 with multiple diagnoses to include [REDACTED] and [REDACTED].</p> <p>Record review revealed the resident was taking</p>	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505452	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/13/2013
NAME OF PROVIDER OR SUPPLIER MESSENGER HOUSE CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 10861 NE MANITOU PARK BLVD BAINBRIDGE ISLAND, WA 98110		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 281	<p>Continued From page 12 multiple medications to include [REDACTED] [REDACTED] [REDACTED] and [REDACTED] ([REDACTED]) medication.</p> <p>Review of the record revealed a physician order dated 10/4/12 that orthostatic blood pressures were to be done monthly related to [REDACTED] medication use. Review of the record did not have evidence that orthostatic blood pressures were done for the months of November 2012 and December 2012.</p> <p>On 2/12/13 at 9:10 a.m., Staff D confirmed orthostatic blood pressures were not done for the months of November 2012 and December 2012.</p> <p>RESIDENT #1 Resident #1 was admitted to the facility on [REDACTED] 11 and had multiple diagnoses to include [REDACTED] and [REDACTED].</p> <p>The resident was taking multiple medications to include [REDACTED] (an [REDACTED] medication) and [REDACTED] (an [REDACTED] medication). Review of the record revealed physician orders that directed staff to obtain orthostatic blood pressures if resident able to stand.</p> <p>The MDS dated 12/17/12 identified the resident required assistance from one staff member with transfers and assistance from one staff member with walking in room and in corridor.</p> <p>On 2/12/13 record review did not contain evidence that orthostatic blood pressures were taken for the months of October 2012 and November 2012. Further review of the record revealed an initial in the box for 12/15/12, but the</p>	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505452	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/13/2013	
NAME OF PROVIDER OR SUPPLIER MESSENGER HOUSE CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 10861 NE MANITOU PARK BLVD BAINBRIDGE ISLAND, WA 98110		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	<p>Continued From page 13 record did not contain the results of an orthostatic blood pressure.</p> <p>On 2/12/13 at 9:16 a.m., Staff B confirmed that orthostatic blood pressures for the months of October 2012, November 2012 and December 2012 were not done.</p> <p>RESIDENT #48 Resident #48 was admitted to the facility on [REDACTED] 12 and had multiple diagnoses to include [REDACTED], and [REDACTED].</p> <p>MDS dated 12/9/12 identified that the resident was one person extensive assist with transfers, walking in room, and walking in corridor.</p> <p>Record review revealed that the resident was taking multiple medications to include [REDACTED] (an [REDACTED] medication) and [REDACTED] (an [REDACTED] medication). Further review a physician order which directed staff to do orthostatic blood pressures monthly if resident able to stand. Orthostatic blood pressures for the months of November 2012 and December 2012 were not done.</p> <p>During an interview 2/12/13 at 9:10 a.m., Staff D confirmed that orthostatic blood pressures for November 2012 and December 2012 had not been done.</p>	F 281		
F 329 SS=E	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or</p>	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505452	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/13/2013
NAME OF PROVIDER OR SUPPLIER MESSENGER HOUSE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 10861 NE MANITOU PARK BLVD BAINBRIDGE ISLAND, WA 98110		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	<p>Continued From page 14</p> <p>without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to consistently monitor for all potential side effects related to use of psychoactive medications for 6 of 10 Sampled Residents (#s 1, 16, 18, 33, 48 & 78). The facility also failed to follow through with recommendations to consider dose reduction of medications for 1 of 10 Sampled Residents (#33) reviewed for unnecessary medication use of the 36 Sampled residents who were included in the Stage 2 review.</p> <p>Findings include:</p>	F 329	<p>F 329</p> <p>Resident # 1, 16, 18, 33, 48, and 78 have had their postural blood pressures completed for February 2013 per current Physician orders. Documentation of February's postural blood pressures has been placed on the individual residents MAR (Medication Administration Record).</p> <p>Postural blood pressure guidelines have been developed in accordance with the Medical Director Dr. Sabrina Benjamin's instructions.</p> <p>Licensed staff have been re-educated per facility guidelines for postural blood pressures related to antipsychotic or antidepressant medications.</p> <p>Compliance with postural blood pressure guidelines related to antipsychotic/antidepressant medications will be followed with routine medication administration record audits per DNS or designee.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505452	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/13/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MESSENGER HOUSE CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 10861 NE MANITOU PARK BLVD BAINBRIDGE ISLAND, WA 98110
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 329	<p>Continued From page 15</p> <p>Orthostatic hypotension is a sudden and significant change in blood pressure that can occur during changes of body position such as lying to sitting and sitting to standing that could cause fainting. Potential side effects of some psychoactive medications increase the risk of orthostatic hypotension. Orthostatic blood pressure monitoring consists of taking resident blood pressures when lying, sitting and standing to assess for significant drops in blood pressure that could increase risks for falls.</p> <p>RESIDENT #33 An Admission face Sheet identified Resident #33 admitted to the facility in 2010. The current Physician's Orders Sheet dated 2/1/13 identified the physician prescribed multiple [REDACTED] medications that included an order for an [REDACTED] medication dated 8/23/11 to treat [REDACTED] a with [REDACTED].</p> <p>On 10/25/12 the physician ordered a medication to treat [REDACTED], [REDACTED], [REDACTED] to be given at bedtime. On 11/23/12 Physician orders identified the physician ordered a second [REDACTED] given at bedtime ([REDACTED]).</p> <p>On 2/13/13 at 8:50 a.m., Staff D reported [REDACTED] was ordered to treat [REDACTED].</p> <p>Dose Reduction Recommendations:</p> <p>A "Consultant Pharmacist's Medication Regimen Review" dated 10/12/12 recommended to consider a trial dose reduction of [REDACTED] or to add lowest effective dose to the physician order.</p> <p>A health provider note written on the bottom of</p>	F 329	<p>For resident #33, ARNP considered the recommendations and the residents final determination has been obtained and placed in the medical record.</p> <p>Licensed staff has been educated on documentation for psychotropic medications.</p> <p>Compliance will be followed per DNS or designee with routine documentation audits during Change of Condition meetings Monday to Friday.</p> <p>The facility's DNS will be responsible to monitor for correction.</p>	3/8/13
-------	---	-------	---	--------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505452	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/13/2013
NAME OF PROVIDER OR SUPPLIER MESSENGER HOUSE CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 10861 NE MANITOU PARK BLVD BAINBRIDGE ISLAND, WA 98110		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 329	<p>Continued From page 16</p> <p>the consultant's report dated 10/25/12 directed staff to reduce the dose of [REDACTED]. A nursing note dated 10/25/12 documented the health provider later discontinued the order to reduce the medication.</p> <p>A nursing note dated 11/14/12 identified Resident #33 had a psychiatric consultation done. A psychiatric progress note dated 11/4/12 indicated the reason for the evaluation was due to a pharmacy consultant recommendation for reduction of [REDACTED].</p> <p>A nursing note dated 11/15/12 documented the health provider would be in the facility the following week to "look over all recommendations".</p> <p>Resident #33's medical record did not contain additional information regarding follow up related to recommendations to consider dose reductions for [REDACTED] and [REDACTED] or documented clinical rationale why attempted dose reductions were not warranted.</p> <p>On 2/12/13 at 8:20 a.m. the surveyor discussed dose reduction recommendations with Staff B and with Staff F and requested additional information to support what determinations were made regarding the medications. Staff F reported he/she did not locate any other notes.</p> <p>Orthostatic Blood Pressure Monitoring:</p> <p>On 2/12/13 at 10:16 a.m. two staff held Resident #33's hands and assisted the resident to walk down the hall to his/her room.</p>	F 329		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505452	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/13/2013
NAME OF PROVIDER OR SUPPLIER MESSENGER HOUSE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 10861 NE MANITOU PARK BLVD BAINBRIDGE ISLAND, WA 98110		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	<p>Continued From page 17</p> <p>Facility incident reports identified the facility investigated multiple falls the resident experienced between 10/20/12 and 1/26/13.</p> <p>Resident #33's medication records identified staff administered an [REDACTED] medication twice a day and two different [REDACTED] medications daily at bedtime.</p> <p>The resident's record did not contain evidence the facility monitored for potential side effect of [REDACTED] during November 2012, December 2012 and January 2013.</p> <p>On 2/13/13 at 8:50 a.m. with Staff D and on 2/13/13 at 8:58 a.m. with Staff B, both staff reported residents who took [REDACTED] medications including [REDACTED] should be monitored monthly for orthostatic blood pressures. Staff D also confirmed Resident #33 had a history of falls.</p> <p>Failure to consistently monitor Resident #33 for [REDACTED] had the potential for staff to not timely recognize if the resident developed significant drops in blood pressure that could contribute to falls.</p> <p>RESIDENT #16 An Admission Face Sheet identified Resident #16 admitted to the facility on [REDACTED] 12. The Current Physician's Orders Sheet for February 2013 identified the resident had diagnoses that included [REDACTED] with [REDACTED], other [REDACTED] and [REDACTED]. Medications prescribed 5/9/12 included the use of two [REDACTED], one given to treat [REDACTED] and one given at bedtime to treat [REDACTED]</p>	F 329			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505452	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/13/2013	
NAME OF PROVIDER OR SUPPLIER MESSENGER HOUSE CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 10861 NE MANITOU PARK BLVD BAINBRIDGE ISLAND, WA 98110		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	<p>Continued From page 18</p> <p>██████████ and on 5/12/12 a different medication to treat high blood pressure.</p> <p>On 2/8/13 at 9:10 a.m. Resident #16 got up from the table and walked down the hall to his/her room independently using a four wheeled walker.</p> <p>On 2/11 at approximately 9:58 a.m. the resident walked out of the bathroom independently without using the four wheeled walker.</p> <p>The facility incident reporting log identified on 1/9/13 Resident #16 experienced a fall. The investigation identified the resident self-reported feeling dizzy and he/she had a fall in the bathroom. The facility monitored the resident to rule out potential effects of blood pressure medication and for ██████████</p> <p>Review of Treatment Sheets identified beginning 5/9/12, staff were directed to monitor the resident for ██████████ on monthly. The resident's record did not contain evidence the facility conducted monitoring during November 2012 or December 2012 until the resident self-reported being dizzy and fell in the bathroom on 1/9/13.</p> <p>On 2/12/13 at 1:15 p.m. Staff B could not locate evidence staff monitored Resident #16 for orthostatic hypotension during November 2012 and December 2012 and did not know why it had not been done.</p> <p>RESIDENT #78 Resident #78 was admitted to the facility on ██████████ 12 and had multiple diagnoses to include ██████████ state and ██████████.</p>	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505452	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/13/2013	
NAME OF PROVIDER OR SUPPLIER MESSENGER HOUSE CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 10861 NE MANITOU PARK BLVD BAINBRIDGE ISLAND, WA 98110		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	<p>Continued From page 19</p> <p>MDS dated 11/15/12 identified that the resident required assistance of one staff member for transfers, walking in room and corridor.</p> <p>Record review revealed the resident was taking medication to include [REDACTED] (an [REDACTED] drug) and [REDACTED] (an [REDACTED] drug). Further review of the record revealed orthostatic blood pressures were not done for the months of November 2012 and December 2012.</p> <p>On 2/12/13 at 7:36 a.m., Staff D confirmed orthostatic blood pressures were not done for the months of November 2012 and December 2012.</p> <p>RESIDENT #18 Resident #18 was admitted to the facility on [REDACTED] 11 and had with multiple diagnoses to include [REDACTED] and [REDACTED].</p> <p>MDS dated 1/10/13 identified that the resident required the assistance of one staff member for transfers, and the assistance of one staff member with walking in room and corridor.</p> <p>Record review revealed the resident was taking multiple medications to include [REDACTED] (an [REDACTED]) and [REDACTED] (an [REDACTED]) medication. Review of the record revealed a physician order dated 10/4/12 that orthostatic blood pressures were to be done monthly related to [REDACTED] medication use. Further review of the record revealed orthostatic blood pressures were not done for the months of November 2012 and December 2012.</p> <p>On 2/12/13 at 9:10 a.m., Staff D confirmed</p>	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505452	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/13/2013	
NAME OF PROVIDER OR SUPPLIER MESSENGER HOUSE CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 10861 NE MANITOU PARK BLVD BAINBRIDGE ISLAND, WA 98110		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	<p>Continued From page 20</p> <p>orthostatic blood pressures were not done for the months of November 2012 and December 2012.</p> <p>RESIDENT #1 Resident #1 was admitted to the facility on [REDACTED] '11 and had multiple diagnoses to include [REDACTED] and [REDACTED].</p> <p>MDS dated 12/17/12 identified the resident required the assistance of one staff member for transfers, and the assistance of one staff member with walking in room and corridor.</p> <p>Record review revealed the resident was taking multiple medications to include [REDACTED] (an [REDACTED] medication) and [REDACTED] (an [REDACTED] medication). Review of the record revealed physician orders that directed staff to obtain orthostatic blood pressures if resident able to stand.</p> <p>On 2/12/13 record review did not contain evidence that orthostatic blood pressures were taken for the months of October 2012 and November 2012. Further review of the record revealed an initial in the box for 12/15/12, but the record did not contain the results of an orthostatic blood pressure.</p> <p>On 2/12/13 at 0916, Staff B confirmed orthostatic blood pressures for the months of October 2012, November 2012 and December 2012 were not done.</p> <p>RESIDENT #48 Resident #48 was admitted to the facility on [REDACTED] /12 and had multiple diagnoses to include [REDACTED], and [REDACTED].</p>	F 329		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505452	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/13/2013	
NAME OF PROVIDER OR SUPPLIER MESSENGER HOUSE CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 10861 NE MANITOU PARK BLVD BAINBRIDGE ISLAND, WA 98110		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	<p>Continued From page 21</p> <p>MDS dated 12/9/12 identified the resident required the assistance of one person with transfers, and the assistance of one staff member with walking in room and corridor.</p> <p>Record review revealed that the resident was taking multiple medications to include [REDACTED] (an [REDACTED] medication) and [REDACTED] (an [REDACTED] medication). Further review a physician order which directed staff to do orthostatic blood pressures monthly if resident able to stand. Further review of the record revealed orthostatic blood pressures for the months of November 2012 and December 2012 were not done.</p> <p>On 2/12/13 at 9:10 a.m., Staff D confirmed that orthostatic blood pressures for November 2012 and December 2012 had not been done.</p> <p>On 2/12/13, review of the facility's undated policy related to [REDACTED] medication documented "each resident on psychoactive medication will be monitored for side-effects, the opportunity to reduce the dose of medication, and whenever possible to discontinue to use of psychoactive medication".</p> <p>On 2/13/13 at 8:50 a.m. Staff D reported the facility just started doing monthly postural orthostatic blood pressures on 10/24/12 in collaboration with a physician.</p>	F 329		
F 371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or</p>	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505452	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/13/2013
NAME OF PROVIDER OR SUPPLIER MESSENGER HOUSE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 10861 NE MANITOU PARK BLVD BAINBRIDGE ISLAND, WA 98110		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	<p>Continued From page 22</p> <p>considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to maintain a sanitary environment while serving glasses of milk in 1 of 3 Dining Rooms (100 Unit). This failure placed residents at risk for drinking milk from glasses with rims that were not maintained in a clean condition.</p> <p>Findings include:</p> <p>On 2/6/13 at 12:20 p.m., during the lunch meal in the 100 Unit Dining Room, the top shelf of a mobile refreshment cart was completely filled with uncovered glasses of milk. Since no more space was available on the top shelf of the cart, a small blue serving tray filled with additional un-covered glasses of milk was stacked on top of the uncovered glasses of milk on the top shelf of the mobile refreshment cart.</p> <p>An unidentified staff was observed to repeatedly place the small blue serving tray of uncovered milk glasses onto unclean surfaces and put it back on the top of the uncovered glasses of milk positioned on top shelf of the mobile refreshment cart.</p>	F 371	<p>F 371</p> <p>For observations made in the 100 Unit Dining Room, in order to maintain a sanitary environment while distributing or serving beverages, items such as serving trays are not to be placed on beverage containers thus avoiding the potential for cross contamination.</p> <p>Sanitary conditions will be maintained while distributing and serving beverages in all dining areas.</p> <p>Staff has been re-educated on sanitary distribution and serving practices to avoid recurrence.</p> <p>The facility's Dietary Manager as part of the Dietary QI will monitor for compliance and be responsible for correction.</p>	3/8/13	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505452	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/13/2013
NAME OF PROVIDER OR SUPPLIER MESSENGER HOUSE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 10861 NE MANITOU PARK BLVD BAINBRIDGE ISLAND, WA 98110		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	Continued From page 23 On 2/12/13 at 10:16 am Staff T agreed the glasses of milk should have been covered. Staff T reported having some new staff which might have contributed to the glasses of milk not being covered.	F 371	F 464 See correction for F 241 also.		
F 464 SS=D	483.70(g) REQUIREMENTS FOR DINING & ACTIVITY ROOMS The facility must provide one or more rooms designated for resident dining and activities. These rooms must be well lighted; be well ventilated, with nonsmoking areas identified; be adequately furnished; and have sufficient space to accommodate all activities. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to provide adequate dining furniture for 1 Sampled Resident (#59) in 1 of 3 Dining Rooms (400 Unit). This failure had the potential to prevent the resident from maintaining dignity during dining. Findings Include: Resident #59 was admitted to the facility on [REDACTED] 09 with multiple diagnoses to include [REDACTED] and [REDACTED]. The [REDACTED] in the resident's back caused her to sit in an overly [REDACTED]. On 2/8/13 at 8:50 a.m., Resident #59 was observed to be assisted by unidentified staff	F 464	Resident #59 has been provided with an adjustable table which is appropriate for her height. The table allows her to be able to sit with her legs appropriately under the table. Residents will be reviewed after admission and as needed for appropriate height tables/dining room equipment needs with special equipment needs implemented as necessary. Dining room/equipment needs will be followed and checked during routine meal observations per DNS and or designee. The facility's DNS will be responsible to monitor for correction.	2/19/13	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505452	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/13/2013	
NAME OF PROVIDER OR SUPPLIER MESSENGER HOUSE CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 10861 NE MANITOU PARK BLVD BAINBRIDGE ISLAND, WA 98110		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 464	<p>Continued From page 24</p> <p>members to a chair to eat at a small table to accommodate her height and medical condition. The small table had an extra piece of decorative wood underneath. This extra piece of wood prevented the table from being placed over the residents legs which would have allowed her to sit closer to the table.</p> <p>The wood piece under the table created a space of approximately 10 inches between the resident and the table. The space between the resident and the table made it difficult for the resident feed herself without spilling food.</p> <p>On 2/8/09 at 9:06 a.m., Staff N was observed to place a clothing protector on the residents lap, and placed the bowl on top of the clothing protector on her lap so she could reach her food. When asked, Staff N reported that the resident preferred to eat with that set up.</p> <p>Staff N also reported that the resident could not sit close to the table, because the "lip" under the table would not allow the table to be placed over her lap without hitting her knees.</p> <p>Failure to provide adequate furnishings prevented the resident from maintaining dignity during dining. Refer to F241 for additional observations related to loss of dignity during dining.</p>	F 464		