Recd 6/6/02

Amendments to POC per Telephone with Administrat 06/12/02 1030 MW

POC acceptable Bradshaw RN

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 5/23/
FORM APPROVE
2567

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104	COMPLAINT NUMBER. 6370, 6372

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F 221 SS=J	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on review of the facility's polices, review of the medical records, and staff interviews it was determined the facility did not ensure that 3 of 4 residents were free from physical restraints via seclusion, imposed for purposes of discipline or convenience, and not required to treat the resident's symptoms. Residents 1, 2, and 4. Findings include: 1. The facility has as part of their programmatic physical structure, a 12 bed unit called the New Direction unit (NDU). The NDU is a secure unit requiring a key that is in the facility staff's possession to enter or exit the unit. Residents placed on the NDU are secluded from the rest of the residents residing in the facility as they are not allowed to move freely or independently outside of the NDU. 2. On 5/8/02, the facility provided it's policy concerning the NDU to the survey team. The policy stated the NDU provided a higher staff to resident ratio along with special programming to reduce the risk of emotional and physical harm secondary to poor judgement skills and behaviors of cognitively impaired residents. Residents eligible for placement in the NDU are those who were cognitively impaired as determined by a physicians diagnosis, laboratory tests, MDS (minimum data set comprehensive assessments), and the Interdisciplinary Team (IDT) determination.	F 221	**F-221** **The NDU (New Directions Unit) Policy and Procedures will be followed directly to insure that improper restraint of a resident does not occur. This is outlined briefly below, and a copy of the NDU Policy and Procedures are attached.** **As stated in this policy, the use of any form of restraint is subject to review by the IDT (Inter Disciplinary Team). Even this team cannot, by itself impose the restraint of a patient. As listed in the procedure, the patient, patient family, and the physician are also included in the decision. Even when utilized, the least restrictive means are to be used with ongoing reviews to determine any change in need. Assessments of at risk residents have been completed and not just "rubber stamped" to meet the true requirement of least restrictive. The assessments will also include alternative interaction with the resident to address needs. i.e. If a resident continually remains an AWOL risk then the function of the facility will also be reviewed with the resident to try and comprehend the perceptions of the resident that warrant the need for him to try to leave. Adjustments with activities, diet, interaction with others, etc. will be revised**	6/8/02

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
John Coppedge	Administrator	6-6-02

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days aft such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 221	Continued From page 1 The policy states the NDU will not accept residents for the purpose of: "1. Staff convenience 2. Involuntary seclusion 3. Punitive punishment 4. Intermittent behavior management... " RESIDENT 2 Resident 2 was admitted to the facility on 5/31/01, with diagnoses of paranoid schizophrenia, cognitive disorder with behaviors, depression, suicidal ideations, insulin dependant diabetes, and polysubstance and alcohol abuse. Resident 2's medical record was reviewed on 5/7/02. 1. Review of the facility's contract agreement with resident 2, dated 6/13/01, indicated the following: "I [resident 2], enter into this agreement with [the facility]. I understand I will: (1). I will have my money's managed through [mental health caseworker]. (2). Not use illegal drugs or alcohol. (3). Agree to attend drug and alcohol groups through [outpatient mental health]. (4). Agree to have urine and /or blood drug screen tests done on a monthly basis and /or at the staffs discretion. (5). Go to Social Services or RN [registered nurse]/DON [Director of Nursing] when I feel depressed, sad, have pressure from other residents, or have need/desire to do illegal drugs or alcohol. Upon completion of the above I will be allowed to go into the community on a daily basis. If I do not comply with the above, I will voluntarily place myself on the locked unit for self protection." This form was signed by resident 2, the Social Service representatives, and the Social worker on 6/13/01.	F 221	**to accomplish a more satisfying environment for the resident. Another remedy is that, if it is found to be impossible to modify the perception of the residents desire to leave then a discharge plan will be put into place that will satisfy the resident, if possible, and the State so that the resident enters a situation that can best meet his/her needs. This system is in place and each team member is aware of their responsibility of on going review, both by the IDT and Quality Assurance. This has been implemented.** **Resident 1 has been assessed and his placement reviewed by the IDT team and independent consultant.** **Resident 2 has been discharged from the facility.** **Resident 4 has been discharged form the facility.** **Other residents in the facility that are in need of a more structured environment such as these three residents will be assessed and monitored per the policy and procedures of the New Directions Unit. Any new admissions will receive the same protocol if a more structured environment is suspected or indicated.**	6/8/02

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F 221	Continued From page 2 The physician did not sign this form. There was no further documentation found in the resident's medical record to evidence the physician was involved in developing the facility's contract agreement with resident 2. 2. Review of the physician's orders from admission on 5/31/01 through 5/7/02 evidenced no documentation that the physician gave orders for the resident to be placed in the NDU. 3. The mental health physician's notes, dated 1/24/02, stated "...On 12/26/01, [resident 2] was put on the closed/locked unit due to his repeated calls to 911. " 4. The IDT (Interdisciplinary Team) meeting minutes were reviewed for the dates of 5/31/01 through 4/2/02. No documentation was found to evidence the resident's attending physician was an active member of the IDT team. Documentation of the IDT meeting for the date 2/21/02 indicated the following: "... Plan of Care: Nursing...Placed on NDU [secondary to] phone calls made to emerg. [emergency] services...Summary of Care Plan Conference Discussion. Pt moved out of NDU in Feb. [February] [with] 1 episode noted of inapp. [inappropriate] phone use. Will monitor for cont. [continued] episodes. Pt informed if episodes cont. [continue] he will be placed on NDU again." There was no documentation found in the IDT meetings regarding the specific dates of when resident 2 was placed in the NDU or when he was released from the NDU. 5. The nurse's notes were reviewed from 5/31/01 through 4/2/02. Documentation included the	F 221	Even if placement on the NDU does occur, follow up of the placement will occur per the policy and procedure of the New Directions Unit. Please see attached. To ensure that we are in and remain in compliance the facility has hired an independent consultant to review our procedure of assessment and behavior management. This is per the directed plan of correction. The facility has already received the initial consultation report and the first weekly report. A copy of these are attached indicating our progress and compliance with the directed plan. The IDT team has been inserviced to ensure that the system is in place is to make good judgement regarding the finding of resident assessments and effective followup of useful behavior management plans. This inservice was held on June 4th and given by the independent consultant. This plan of correction was reviewed by the Quality Assurance Committee on June 4, 2002. This plan will be monitored by the	6/8/02

SD 80240 WM

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F 221	Continued From page 3	F 221		

following:

12/25/01 at 5:45 PM: "Pt [patient] came up to nurses station and said he just called the paramedics. I asked why and he said he was hearing voices to kill himself."

12/25/01 at 6:00 PM: "Paramedics arrived. Obtained Pt information et (and) stated that they would probably be taking Pt to [hospital] for eval [evaluation)."

12/26/01 at 12:15 AM: "Pt back to facility from[hospital] ER [emergency room] via cab..."

There was no documentation found in the nurse's notes that the resident was placed on the NDU on 12/26/01 as per the mental health physician's documentation on 1/24/02. The first nurse's note to document that resident 2 was residing on the NDU was: 1/17/02 at 9:30 AM: "...Amb. ad lib [at liberty] in NDU ..."

The nurses notes did not document a date that the resident left the NDU, moving to the open, non-secure area of the facility to reside. The nurses notes, however, continued to document incidents of AWOL behaviors and the placement of resident 2 in the NDU in March 2002.

3/6/02: "Pt noted by CNA [certified nurse aide] to have left room and facility [without] signing out...Social Work office notified...instructed to place pt on locked Alzheimer unit upon his arrival back to facility."

Nurse's notes documented the resident returned to the facility on 3/8/02, however there was no documentation noted that the resident was placed in the NDU on that date.

QA Committee not less than each quarter. However, the initial implementation will be reviewed by the independent consultant and included on his weekly review to insure, and provide documentation of compliance, and that an effective plan has been placed into affect. 6/8/02

The Administrator has coordinated this effort with the Director of Nursing who will monitor the procedure and be responsible that this plan is followed. The director of nursing will make a follow up report at the Quarterly Quality Assurance Meetings. These reports will not only include that Policy and Procedure have been followed, but also any recommendations for implovement will be reviewed and implemented if warranted.

DON/IDT will meet weekly for one month then every month.

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F 221	Continued From page 4	F 221		

3/29/02 at 5:00 PM: "Police came to desk and stated [resident 2] called and said that [another resident] was following him all over the facility and threatening him [with] a knife - pt. did not notify any of the staff. Story not substantiated by any witnesses, staff or residents...pt. placed in NDU for more structured environment/supervision."

6. Review of resident 2's Plan of Care, dated 6/13/01, evidenced the following:

"Problem #1: Alteration in behavior r/t [related to] worsening of chronic illness....Approach:...7. Res. [resident] is not to leave facility unsupervised [without] staff or [without] approval from IDT."

7. The Social Service representative was interviewed on 5/8/02 at 3:00 PM. When asked if the facility had a system in place to assess and evaluate residents for placement on the NDU, she stated, "No."

8. The DON was interviewed on 5/9/02. When asked if the facility had a systematic process in place to implement a least restrictive restraint and to assess residents before they are placed on the NDU, the DON stated they do not have a formal process in place.

9. The facility did not develop or follow a systematic process to evaluate and care plan the placement of resident 2 on the NDU. The facility did not assess or implement less restrictive measures prior to using the NDU as a restraint, or update the plan of care to reflect the placement of resident 2 on the NDU.

10. There was no documentation found to evidence the IDT meetings included the resident's physician in the decision to place the resident on the NDU.

11. Resident 2 was placed at least 2 times in the

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F 221	Continued From page 5	F 221		

facility's secure NDU from 12/26/01 until 3/6/02. Length of stay is not indicated specifically, however, documentation shows that the stays in the NDU were not of a temporary or short term matter and were not reflective of the conditions the resident agreed to in his facility generated behavior contract. The facility consistently documents that the behaviors exhibited by resident 2 which resulted in NDU placement were the inappropriate use of the telephone to contact emergency services.

RESIDENT 1

Resident 1 was a 42 year old male resident admitted to the facility on 8/7/01, with the following diagnoses: traumatic head injury, severe cognitive deficit with aggressive behaviors and aphasia (difficulty communicating). Resident 1 was admitted to the open area of the facility (not in the locked secure unit).

Review of resident 1's medical record on 5/9/02 revealed the following:

1. Review of the admission MDS dated 8/14/01 indicated that the resident had problems with short and long term memory, moderately impaired cognitive skills (decisions poor, cues/supervision required). Indicators of delirium and disordered thinking were also documented including; easily distracted and periods of restlessness. He was targeted as having difficulty with communication: "Sometimes understood [ability is limited to making concrete requests]", and "Sometimes understands-[responds adequately to simple, direct communication]". He was noted to have indicators of anxiety evidenced by asking; "Repetitive questions-e.g....., Where do I go? What do I do?". He also had verbally abusive behavior which occurred on 1 to 3 days in a week. Resident 1 was also documented as being independent

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F 221	Continued From page 6 with walking. The assessment indicated that the resident had a legal guardian. 2. Review of the current recertification of Physician's Orders for the period of March 26, 2002 to May 26 of 2002, revealed a house order for leave of absence status. It stated "[May] go out on pass with [family, staff] [with] medications". 3. Social Service Progress notes documented the following: A social service note dated 8/7/01, the day of admission, indicated the resident had a traumatic brain injury and severe cognitive deficit. "Resident is oriented to his name and with reminders can find his room." A note dated 8/16/01 documented that the "Resident is at risk for AWOL. He leaves the facility and wanting to go home." Notes dated 9/27/01 stated the following: "No progress shown with decreasing risk at AWOL. Resident has several episodes of successfully going AWOL from facility. Police were notified of every incident and police have brought resident back to facility unharmed. Wife has purchased ID bractlet with Midtown information.....Resident short term memory is very poor." A note dated 11/8/01 stated: "Resident has had several episodes of going AWOL from facility, because he wants to go home. Resident does wear a ID bracelet and has always been brought back by police safely. Signs have been posted at front door to prevent him from leaving facility". 4. An interview was conducted on 5/10/02, at 2:30	F 221		

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F 221	Continued From page 7	F 221		

PM with the director of nurses, where he made reference to the signs. He indicated that signs were posted on the front door of the facility to stop resident 1 when leaving the facility. He stated it worked well for a while but later seemed to have no effect. The sign was observed by the surveyor and it directed residents to stop and be sure to check out prior to leaving. The sign was not specifically directed to resident 1.

5. Social services progress note dated 4/18/02, stated: "Resident recently placed on NDU for structure environment due to going AWOL from facility numerous times. Poses himself to being a danger to self. Resident successfully made it to the airport and was brought back by police. Resident is unaware of his surrounding and whereabouts. Resident has always agreed to return to facility and does wear a ID bracelet. Resident is not adjusting well to being on NDU and has had an increase in behaviors and attempts to go AWOL when going to activities +/or [and or]meals....Resident will continue to reside on NDU for structure environment and for his safety."

The social service progress notes did not document when resident 1 was placed in the unit, who was involved in the decision making, if the physician was involved or the assessment process that was used to determine the need for placement. The notes did document an increase in behaviors.

6. Interview with the Social Service representative, on 5/9/02, indicated that the resident's guardian was notified and agreed to the placement in the secure unit. When questioned about who made the decision to place residents in the unit she stated usually the IDT (interdisciplinary team) would discuss it along with the administrator. She stated resident 1 was placed in the NDU after he went AWOL and was found at the

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F 221	Continued From page 8	F 221		

airport.

7. Review of the physicians orders revealed there was no physician's order in resident 1's medical record for him to be placed in the NDU.

8. Review of the Care Plan Conference Summaries revealed the following (The summaries are brief notes documenting IDT meetings which are held at least quarterly and resident care issues and care plan goals are discussed):

The care plan summary for the second quarter dated 1/31/02, documented the following: "decreasing episodes of hitting, verbal, cursing down, AWOLs down".

The care plan summary for the third quarter, dated 4/18/02, documented that the resident had been noted to have an increase in behaviors after he was placed in the unit: "Pt. placed on NDU due to ongoing AWOL episodes....Pt. will AWOL with outside NDU activity - activities must be in NDU...Physical, verbal outbursts, AWOL episodes.... Pt. with physical outbursts with redirection back to NDU."

9. The care plan summary for an MDS status change dated 5/2/02, documented the following: "Memory deficit due to TBI [traumatic brain injury] placed on the NDU. Behaviors-physically abusive increased....Attended bingo out of NDU and stayed - did leave activity in the day room [also out of the NDU].... Increased behaviors-hitting, verbal-cont. [continued] attempted AWOLs....ongoing combative episodes physically attacking staff. Long term care. Physical outbursts towards staff since being placed on NDU".

In the portion of the form titled "Summary of Care

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F 221	Continued From page 9	F 221		

Plan Conference Discussion" it stated: "Pt. has had increased episodes of attempted AWOLs - pt physically aggressive with redirection back to NDU." The IDT team identified an increase in behaviors during this meeting, which was held eight weeks after resident 1 was placed in the NDU.

10. Review of the nurses notes revealed ongoing incidents of AWOL from the date of admission 8/7/01 to 3/11/02, when the resident was placed in the NDU.

A note dated 3/11/02, documented the following: At 9:00 AM. "Pt. AWOL family and SLPD [Salt Lake Police Department] notified." At 5:00 PM "Pt returned to the facility - staff located pt. at SL airport - pt. placed in NDU - locked unit for more structured environment due to AWOL behavior - will cont. [continue] to monitor. Family notified." The nurse's note did not document the decision making process involved in placing resident 1 in the secured NDU. There was no documentation of who was involved in the decision i.e. staff members, physician. There was no indication in the note about whether the family member was notified simply of the AWOL, or if the guardian was actively involved in making the decision to place the resident in the NDU.

A note dated 3/19/02, eight days after it appears the resident was transferred into the NDU, documented that: "resident 1 was seen by the physician for an increase in behaviors." New medication orders were given in order to decrease the agitation and a behavior management plan was ordered.

A note written on 4/24/02, six weeks after admission to the NDU, indicated that resident 1 "continues with some behaviors no significant changes noted".

The resident had displayed an increase of behaviors,

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F 221	Continued From page 10	F 221		

for which the staff requested additional medications after he was placed on the NDU.

11. The care plan for resident 1 was reviewed. It included Problem #2 regarding an "alteration in behaviors", dated the day of admission (8/7/01). This care plan problem was reviewed and continued without change by the IDT on these dates: 8/16/01, 9/27/01, 11/8/01 1/31/02, 4/18/02 and 5/02/02. No change in the care plan was made when the resident was placed in the NDU. The care plan approaches included:

"(1). Document all AWOL attempts on data collection sheets on a 24 hr. basis.
(2). Monitor data collection sheets-report any changes to RN/DON.
(3) Monitor res. whereabouts frequently to decrease chances of AWOL.
(4). Provide reassurance/redirection as needed.
(5). If resident is successful in AWOL =
a. Search facility and grounds - announce on PA system.
b. Call police ASAP.
c. Notify RN/DON or owner/Adm. (administrator) also family &/or guardian.
(6). See policy on AWOL.
(7). Use validation techniques to discuss with the resident the emotions behind attempts to leave the facility.
(8). Assure res. is provided with ample physical activities.
(9). If tolerated place bell on wheel chair or shoe string so whereabouts can be readily determined".

There was no indication in the medical record that the care plan approach to: place a bell on the resident's shoe to help keep track of the resident, was tried prior to placement of resident 1 in the unit.

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F 221	Continued From page 11	F 221		

12. Review indicated that resident 1 was placed on a "Behavior Management Plan". It was dated 3/20/02, (nine days after the resident was placed in the secure unit). The behaviors listed were aggression with physical and verbal abuse. The behaviors were noted to revolve around cigarette issues or wanting to go home. The behaviors were directed toward staff, and there was a history of him directing his behaviors toward peers when they would not give him one of their cigarettes. The plan indicated that according to the data collection sheets there had been an increase in physical and verbal abusive behaviors and going AWOL from the facility related to wanting to go home &/or searching for cigarettes. The behavior management plan was not directed towards altering resident 1's AWOL behavior.

The care plan and the behavior management plan made no mention of resident 1 residing in the secure unit which limited the residents ability to move freely about the facility and any additional behavioral manifestation this may have promoted. The only mention of the resident's environment was to "provide a calm, consistent, predictable environment".

There was no documentation indicating what less restrictive alternatives were tried or considered prior to placing resident 4 in the NDU. There was no documentation that the physician was involved in the decision making process. The nurse's notes did not document clearly that the guardian had given consent for the move to the unit. It was not clear that there was a systematic process or criteria used in deciding resident 4 would benefit by placement in the secure unit.

RESIDENT 4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

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F 221	Continued From page 12	F 221		

Resident 4 was admitted to the facility on 1/29/02 with diagnoses that included: dementia with depressive features and behaviors secondary to traumatic brain injury, hypertension, non-insulin dependant diabetes, prostate cancer, and colon cancer.

Review of resident 4's closed medical record on 5/9/02, revealed the following:

1. An admission physician's order, dated 1/29/02, documenting that resident 4 could have LOA (leave of absence) privileges with family or staff, (not independently).

2. Review of the admission MDS, dated 2/11/02, indicated that resident 4 had problems with short and long term memory, moderately impaired cognitive skills (decision making poor, cues/supervision required). Indicators of delirium and disordered thinking were documented as "easily distracted".

He was targeted as having difficulty with communication: "sometimes understood (ability is limited to making concrete requests)", and "Sometimes understands (responds adequately to simple, direct communication)".

Resident 4 had wandering behaviors that occurred 1 to 3 times in a week. He was also documented as being independent with walking.

3. Review of resident 4's undated comprehensive plan of care on 5/9/02, documented under problem 3, that resident 4 was an "AWOL risk per previous history and cognitive impairment".

The approach for this care plan problem included "...3. Monitor residents whereabouts frequently to [decrease] chances of AWOL... 5. If resident is

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F 221	Continued From page 13 successful in AWOL; A. Search the facility & grounds; B. Call police ASAP; C. Notify RN/DON or Admin., also family and/or guardian". 4. The nurses document, from 2/3/02 to 3/1/02 that the resident had no AWOL attempts, but that resident 4 would "wonder aimlessly" in and out of other residents rooms. A nurse's note, dated 3/1/02 at 9:00 PM, stated "Pt. confused and came out frequently in new room (moved noon today). Couldn't sleep at night, observed anxious/nervous, reoriented about new surroundings. Will continue to monitor". A nurses note dated, 3/2/02 at 12:15 PM, documented "...no episodes of AWOL since placed on open unit", indicating that the "move" discussed above was from the secure NDU to the open unit (unsecured). 5. No documentation could be found in resident 4's medical record that an assessment had been made by the IDT and what was involved in the decision making process before placing resident 4 on the open unit. There was no physician's order found indicating to move resident 4 to the open unit. Resident 4's care plan had not been updated to reflect that change. 6. The nurses documented AWOL attempts by resident 4 on 3/2/02, 3/3/02, 3/8/02 and 3/10/02. On 3/12/02 at 7:25 PM, a nurses note documented "CNA reported pt. is not in his room, search made of facility, unable to locate pt. in building. Unable to locate pt outside of bldg. (building) or surrounding area...Call placed to [police]...". At 7:50 PM the nurse documented that a police officer was in the facility.	F 221		

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F 221	Continued From page 14 At 8:45 PM the nurse documented that resident 4 was found in the NDU and the police were notified. 7. A nurses note, dated 3/15/02 at 8:00 PM, documented "Pt. alert et (and) confused ongoing. Is resting in bed at New Directions Unit...". 8. No documentation could be found in resident 4's medical record that an assessment had been made by the IDT or that any system or criteria was used prior to placing resident 4 back on the NDU. There was no physician's order found stating to move resident 4 back to the NDU. Resident 4's care plan had not been updated to reflect the change. 9. A review of resident 4's Care Plan Conference Summaries dated 2/2/02, 2/11/02, 2/28/02 and 3/28/02 all document that resident 4 was an AWOL risk and continued to spend time on NDU. There was no documentation found to show that resident 4's attending physician was an active member of the IDT team. 10. No documentation was available which indicated that other less restrictive alternatives had been tried prior to re-admitting resident 4 to the secure unit.	F 221		
F 224 SS=K	483.13(c)(1)(i) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. (Use F224 for deficiencies concerning mistreatment, neglect or misappropriation of resident property.)	F 224		

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F 224	Continued From page 15 This REQUIREMENT is not met as evidenced by:	F 224	F-224	6/8/02

Based on review of resident medical records, review of facility policies, and staff interviews it was determined that the facility did not assess, care plan and monitor residents with AWOL (absent without leave) behaviors which led to neglect for 5 of 8 sample residents. Neglect is defined as failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Residents 1, 2, 3, 4, and 5.

Findings include:

1. The facility failed to establish and implement policies which identified situations which constitute neglect including failure to identify the abandonment of residents by a charge nurse, AWOL residents, missing residents, involuntary seclusion of residents and other situations which resulted in residents not receiving needed services that the facility was responsible to provide.

2. The facility additionally failed to implement the already established policy regarding steps to be taken when residents were determined to be missing.

3. On 5/8/02, the facility's "Missing Patient Procedure" policy was reviewed.

In summary, the policy states that the aide assigned to a given resident is responsible for knowing where their assigned residents are at all times. If a resident is missing, the aide is to notify the charge nurse and a search is begun. An organized search is to start after 10 to 15 minutes has occurred. The policy states:

" When notified by an attendant that a patient is missing, the nursing supervisor is to immediately notify other supervisors . . . Time is a major factor in finding missing patients. Immediate danger is present

Resident 1 has been assessed for appropriate placement on the NDU with the proper procedure having been followed and reviewed by the independent consultant. The NDU policy and procedure will be followed for continued review.

Resident 2 has been discharged.

Resident 3 has been discharged.

Resident 4 has been discharged.

Resident 5, who is not on the NDU has been evaluated and received new LOA requirements that are less restrictive. This was reviewed by Valley Mental Health, the QA Committee and the residents doctor.

Resident 7 has been discharged.

All current residents' LOA requirements have been reviewed and updated. New Admissions will be reviewed by IDT team.

To protect other current residents, and to have an ongoing plan that protects any new admissions the facility has implemented a new protocol and procedure to ensure that

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F 224	Continued From page 16 when elderly patients, particularly those who are confused, are exposed to street traffic, hazardous terrain, or physical exposure to sun, heat, or inclement weather. . . Therefore it is important that missing patients be discovered soon, and that efforts be organized and thorough. . . If preliminary search efforts fail to locate the patient (approximately 1 hour of sustained search), the administrator is to be called, regardless of the day or hour...If the administrator is not available, the director is to be called. The administrator and/or director are to travel to the facility and assume responsibility for the search, and notify outside agencies . . . Police to be notified of patient missing 30 minutes. b. The family or other Responsible Persons...c. The Attending Physician. d. The Health Department..." RESIDENT 2 Resident 2 was admitted to the facility on 5/31/01 with diagnoses of paranoid schizophrenia, cognitive disorder with behaviors, depression, suicidal ideations, insulin dependant diabetes, and polysubstance and alcohol abuse. On 5/7/02 resident 2's medical record was reviewed and on 5/13/02 Salt Lake City Police Department reports were reviewed. Together they documented the following AWOL episodes: 1. 1/6/02 at 6:40 PM facility documents resident "disappeared". Police notified facility that resident tried to commit suicide and transported to the hospital. 2. 3/6/02 11:55 PM (per Salt Lake City Police) to 3/8/02 3:00 PM. Police notified by facility 3/7/02 6:30 AM. Resident time out of facility was 39 hours	F 224	the location of residents are monitored and, that if missing or AWOL, a procedure to locate and report the situation. The attached policy and procedures have been implemented. Training of personnel and ongoing training for new personnel and review for current employees have been initiated. Specific inservices have been held and "spot" checks of employees demonstrating that they have learned and understand the training that has been given has been accomplished. All work shifts have been covered with regard to this training. A brief overview of the training includes: A time frame that each care giver or employee who is responsible for a resident initials that they have personally seen the resident. A copy of this form is attached. There is also a form that the employee signs that indicates the employee has received the training to accomplish the items listed above. A method that monitors residents who are on a leave of absence has been initiated. They are within a timeframe or will be placed on missing / AWOL status. The procedure covers who the employee reports the information that a resident is missing. The immediate follow up of looking for the resident, the time frame in which other agencies are to be notified and specific police reporting requirements are	6/8/02

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 224	Continued From page 17 and police notified 7 hours after AWOL 3. 4/1/02 5:30 AM to 4/2/02 5:00 PM. Police notified by facility 4/2/02 1:00 PM. Police notified 31 1/2 hours after AWOL discovered and resident was found 35 1/2 hours after noted missing. Resident 2's medical record was reviewed on 5/7/02 and documented the following: 1. Review of the physician's orders revealed an order, dated 5/31/01 (the resident's admission date to the facility), stating the resident "May go out on pass with family, staff with medications." This indicated the resident was not to leave the facility unsupervised. 2. Review of the resident 2's Social Service Progress Record, dated 5/31/01 indicated, "...Long term memory is fair and short term memory is poor...He lacks judgement and has little insite into his medical or psychiatric condition..." 3. Review of resident 2's Plan of Care, dated 6/13/01, evidenced the following: Problem #1: "Alteration in behavior r/t [related to] worsening of chronic illness....May be complicated by 1. Behavior that endangers resident...External factors: 1. Poor decision making ability..." Approach: "...7. Res. [resident] is not to leave facility unsupervised [without] staff or [without] approval from IDT (Interdisciplinary Team)." Problem #2: "Alteration in mood r/t cognitive impairments, m/b [manifested by] suicidal actions..." Goals: "Res. [resident] will [decrease] potential of suicide as evident by following thru next review. a. Res. will be free from suicide attempts [with] [no] s/s [signs and symptoms] of physical harm on a daily	F 224	included. A procedure has been implemented so that agencies who received a report of a missing resident are contacted about the residents return and any pertinent data regarding the resident, such as physical condition, etc. This procedure was completed and implemented along with the inservice training. The information is attached. A specific agenda item will be included for discussion at the Quality Assurance Meetings. The effectiveness of these procedures will be reviewed, monitored, and revised if improvements are indicated or recommended. Inservices on the above procedures were given on May 11th; May 13th; May 14th; May 15th; & May 30th. All shifts, and all personnel received this inservice. The inservice was given by the Administrator and Social Services. Follow up training will be done for review of current employees, and orientation for new employees. The schedule for ongoing review of the policy and procedure is a mandatory employee meeting on the third Friday of each month.	6/8/02

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F 224	Continued From page 18 basis. B. Have [no] verbalizations of suicide thoughts/plans on a daily basis." Approach: "...7. Assess Res. suicidal potential + evaluate the level of suicide precautions daily." Documentation on resident 2's Plan of Care evidenced it had been reviewed on 7/26/01, 9/6/01, and 11/24/01. The was no evidence found that the Plan of Care for these problems had been updated or changed by the facility staff on the dates reviewed. 4. Resident 2's Behavior Management Plan, dated 6/13/01, was reviewed and it documented the following: "Problem: Suicide actions/attempts. Several..." Goals: "[No] s/s of physical harm on a daily basis..." Approaches: "...8. Residents whereabouts and activities will be monitored. 9. Resident will be accompanied by a staff member while at activities in or out of the facility. 10. Resident has attempted suicide in the past by obtaining drugs and alcohol from out in the community. Res. will not be allowed to leave facility unsupervised and/or without approval from IDT. 11. Assess resident's suicidal potential and evaluate the level of suicide precautions daily." 5. The nurse's notes were reviewed for the time period of 5/31/01 through 4/2/02. Documentation included the following: 1/6/02 at 6:00 PM: "Pt refused [medication]...took at 18:40 [6:40 PM] and then disappeared..." There was no documentation found to evidence the facility attempted to locate resident 2 or notified the police when the resident disappeared. "...Police officer came into the facility, he stated [resident 2] got a crime number...because he tried to do a suicide in the middle of the road....[the patient was taken to the hospital by	F 224	This will be monitored by the Director of Nursing and part of his report at the Quarterly Quality Assurance Meetings. However, the initial implementation of the plan was reviewed at a Quality Assurance Committee Meeting on June 4, 2002 to insure that viable plan had been placed into effect. DON/IDT will meet weekly x 1 month then every month.	6/8/02

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

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	465124	A. BUILDING _____ B. WING _____	C 5/10/02

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F 224	Continued From page 19 the police]...Called [physician] to notify about [resident's] event and got a new order - Haldol [antipsychotic] 5 mg [milligrams] IM [intramuscular] BID [2 times daily]or PRN [as needed]. Will continue to monitor." 1/7/02 at 7:30 AM: "Pt still AWOL ...Called [hospital] to inquire of Pt whereabouts. They said he left in a cab..." There was no documentation found to evidence the facility notified the police that the resident was AWOL after being released from the hospital. 1/7/02 at 10:45 AM: "Pt returned to facility..." This was 3 hours and 15 minutes after the facility had determined the resident was AWOL. 3/6/02 from 1800 to 0600 [5:00 PM to 6:00 AM]: "Pt noted by CNA [certified nurse aide] to have left room and facility [without] signing out in LOA [leave of absence] book or informing staff. Social Worker office [Social Service representative] contacted [at] place of residence to inform her of event." The nurses note did not document the actual time the resident was determined to be AWOL, if the facility staff had attempted to locate the resident, or if the police had been notified. 3/7/02 at 5:00 AM: "Pt still missing from room at this time. Will continue to monitor and report on situation." 3/7/02 at 6:30 AM: "Administrator notified and police notified...Police will call back facility later on this AM." There was no further documentation found to determine when the police returned the facility's call regarding resident 2 being AWOL. 3/7/02 at 12:00 midnight: "Still AWOL from facility."	F 224		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

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F 224	Continued From page 20	F 224		

3/8/02 at 3:00 PM: "Pt returned to facility via staff assisted from hospital stay." There was no documentation found in the medical record to determine which hospital the resident had been in, when he had been admitted to the hospital or why he was in the hospital.

4/1/02 at 3:00 PM: "Pt has been gone since 0530 [5:30 AM]. Didn't sign out. Didn't report to this nurse. Still hasn't returned to facility..." [There was no documentation found to evidence the facility staff attempted to locate resident 2 or notified the police that the pt was AWOL].

4/2/02 at 10:00 AM: "Pt still remains AWOL."

4/2/02 at 1:00 PM: "Put in a call to police department to report missing Pt. Waiting for officer to call back." This was 35 hours and 30 minutes after the facility documented resident 2 was AWOL.

4/2/02 at 3:30 PM: "Still waiting for police to call back."

4/2/02 at 4:15 PM: "Police returned call. Will try to find pt..."

4/2/02 at 5:00 PM: "Police called + stated they found the pt-he refuses to come back to facility + they cannot force him to. He is staying at [hotel] and getting his meds from [clinic]."

6. On 5/13/02, a review of police reports, dated 3/7/02 and 4/2/02, concerning Resident 2 was conducted revealing the following documentation:

Police report dated 3/7/02: The report documented that incident regarding resident 2 occurred on 3/6/02 at

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 224	Continued From page 21	F 224		

11:55 PM and was reported to the police, by the facility, on 3/7/02 at 6:54 AM (7 hours later). The report further documented, "...the complainant reported that a patient of the care center had walked away around midnight. He is not a court committed patient,..."

Police report dated 4/2/02: The report documented, "I was dispatched to the [facility] on a missing person case. I talked to the nurse who called the police. [Name of Nurse-employee 2] called the police after [resident 2] had been gone for a day and half. She stated [resident 2] has walked away from the facility in the past....I told [employee 2] we have to check the entire facility before we go outside looking for [resident 2]. [Employee 2] was reluctant at first to show me around the facility because her shift was over. There was another worker there that [employee 2] asked to show me around the facility but she refused because she was on the phone. I told [employee 2] I wanted to look in the lock down area first because several weeks ago we were called on a missing person and that person was found in the lock up. [Employee 2] took me to the lock up and then we searched the entire building. We did not find [resident 2] in the building.

I talked to [employee 3] who works at the facility. She said she saw [resident 2] yesterday morning at 0545 [5:45 AM]. He was [name of street] walking towards [name of street]. I asked [employee 2 and employee 3] why the police were not called then. [Employee 2] said because [resident 2] always leaves, but he always returns to get his meds.

Officer [name of officer] and I found out that [resident 2] likes to go to the shelter and [name of park]. We began a car and foot search in that area. We dropped off pictures of [resident 2] to the shelter, the mission,

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 224	Continued From page 22	F 224		

and the food line.

At 1751 [5:51 PM] the workers from the food line called and said [resident 2] was there. Officer [name of officer] went to the line and confirmed it was indeed [resident 2].

In the past 6 months we have been called to the Manor 7 times for walkaways/missing persons."

7. The DON (Director of Nurses) was interviewed on 5/9/02 at 2:30 PM. When asked to describe the facility's policy regarding AWOL resident's, he stated that the CNA's report to the charge nurse if a resident is missing. The staff then conduct a search of the facility , both inside and outside. If the resident is not found within 30 minute, the nurse then notifies the police, the resident's physician and family or guardian. The DON also stated the nurse should fill out an incident report and document the incident in the resident's chart in detail. When asked for the incident reports for resident 2's AWOL events for 1/6/02, 3/6/02 and 4/1/02, the DON was unable to locate the documentation.

8. The facility failed to follow their missing patient policy by not attempting to locate resident 2 or notify the police in a timely manner after determining that he was missing. There was no documentation found that the resident 2's physician was notified consistently when the resident was missing. There was no documentation found in the resident's medical record to evidence the IDT team gave the resident approval to leave the facility unattended. There was no documentation in resident 2's medical record that the facility staff identified and assessed his ongoing AWOL behaviors, updated the Plan of Care to address the AWOL behaviors, or implemented interventions to stop the AWOL behaviors and protect the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 224	Continued From page 23 RESIDENT 5 Resident 5 was admitted to the facility on 8/15/00 with diagnoses of schizoaffective disorder bipolar type, insulin dependant diabetes mellitus and hypertension. On 5/10/02 resident 5's medical record was reviewed and on 5/13/02 Salt Lake City Police Department reports were reviewed. Together they documented the following AWOL episodes: 1. 11/25/01 11:30 AM to 11/28/01 8:00 AM. Police notified on 11/27/01 at 7:30 AM. Time out of the facility was approximately 68 1/2 hours with police notification approximately 44 hours after resident was noted missing. 2. 12/15/01 12:10 AM to 12/15/01 7:30 AM. Police notified at 12:35 AM. Time out of the facility was approximately 7 hours during winter and late at night. The resident's medical record was reviewed on 5/10/02. 1. Review of the current physician's orders revealed an order, dated 8/15/00, stating that resident 5: "May go out on pass with family, staff with medications". This order indicated the resident needed supervision when leaving the facility. 2. Review of the current MDS (Minimu Data Set), dated 3/28/02, evidenced the resident had moderately impaired cognitive skills for daily decision making. 3. Review of resident 5's Plan of Care, dated 8/25/00, evidenced the following: Documentation on the first page of the Plan of Care under LOA privileges indicated the resident may leave	F 224		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 224	Continued From page 24	F 224		

with family or staff. LOA privileges for leaving the facility alone was not documented for resident 5.

Problem #1: "Alteration in Behavior: Elopement risk... m/b [manifested by] Res. leaves the facility without notifying nursing or signing out. Complicated by: 1. Behavior that endangers the res(residents)...External factors: 1. Poor decision making ability. 2. Schizoaffective disorder."
Goals: "Res. will [decrease] risk for elopement as evident by notify nursing + signing out prior to any LOA thru next review."
Approach: "...5. Staff will inform [social services] +/or Admin. [administrator] if res. leaves the facility [without] signing out. 6. Discuss [with] the res. in private after any incidents occur + strongly reinforce compliance [with] facility rules [such as always informing staff + signing out]."

Documentation on the resident's Plan of Care evidenced it had been reviewed on 10/5/00, 11/16/00, 2/8/01, 10/18/01, and 1/10/02. The was no evidence found that the Plan of Care for this problem had been updated or changed by the facility staff on any of these review dates.

4. Review of the Social Service Progress Record revealed the following:

The social service note dated 1/10/02, for resident 5 indicated the following: "Resident conts. [continues] to periodically, when she becomes upset, take off without signing out or letting nursing or anyone know that she is leaving and without medications will be gone 2 or 3 days. Staff have had to call police to notify that she is missing."

5. Review of the IDT meetings revealed the following:

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 224	Continued From page 25 1/10/02: "Care Plan Element...Risks/consequences: Ongoing AWOL'S...Summary of Care Plan Conference Discussion: Multi [multiple] episodes of AWOL ongoing..." 3/28/02: "Care Plan Element...Risks/consequences: Ongoing AWOL..." 6. The nurse's notes for resident 5 were reviewed and revealed the following: 11/26/01 at 5:00 AM: "Yesterday pt was LOA after lunch. Pt. didn't come back at present time. Does not take 11/25/01 noc [night time] meds." No specific time was documented for when the staff noted the resident was AWOL. There was no documentation found regarding the staff attempting to locate the resident or that the police were notified when the staff determined the resident was AWOL. 11/26/01 at 10:00 PM: "Pt is AWOL now..." 11/27/01 at 7:00 AM: "Pt remains AWOL." 11/27/01 at 7:30 AM: "Called and reported missing to police." This was approximately 44 hours after the resident went AWOL. 11/28/01 at 8:00 AM: "Pt did come back to facility. Insulin given..." The resident was AWOL approximately 68 hours and 30 minutes. 12/15/01 at 12:10 AM: "Pt up at nurse's desk, attempted to sign out in LOA [leave of absence] book. Pt informed she could not sign out for LOA [at] this time. Pt again became belligerent, stating she was leaving facility. Pt informed she was not to leave facility + would be AWOL. Pt left the facility [at] this time.	F 224		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 224	Continued From page 26 12/15/01 at 12:30 AM: "Pt has not returned to the facility [at] this time." 12/15/01 at 12:35 AM: "Call placed to SLPD [Salt Lake Police Department] to report pt AWOL. Awaiting call back from SLPD for report to be made + case [number]." 12/15/01 at 2:00 AM: "Pt not back to facility, still awaiting call back from SLPD." 12/15/01 at 7:30 AM: "Pt returned from AWOL, had AM meds and Insulin. [No] apparent problems." 7. Review of a police report on 5/13/02 documented the following incident: The report which was dated 11/27/01, documented that the incident regarding resident 5 occurred on 11/25/01 at 11:30 AM, and was reported by the facility to the police two days later, on 11/27/01 at 8:47 AM. The report further documented, "Comp. [complainant] ...reports the walk away [resident 5] was last seen Sunday 11/25/2001 at about 1130 [11:30 AM]. Has not been seen or heard from her since.... She had walked away a number of times before but always come back the next day, they have no idea where she may be this time." 8. The facility failed to follow their missing patient policy by not attempting to locate resident 5 or notify the police in a timely manner after determining that she was missing. There was no documentation in resident 5's medical record that the facility staff identified and assessed her continual AWOL behaviors, updated the Plan of Care to address the AWOL behaviors, or implemented interventions to stop the AWOL behaviors and protect the resident.	F 224		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 224	Continued From page 27	F 224		

RESIDENT 1

Resident 1 is 42 year old male resident admitted on 8/7/01, with the following diagnoses: traumatic head injury, severe cognitive deficit with aggressive behaviors and aphasia (difficulty communicating).

On 5/8/02 resident 1's medical record was reviewed and on 5/13/02 Salt Lake City Police Department reports were reviewed. Together they documented the following AWOL episodes:

1. 3/11/02 9:00 AM to 3/11/02 at 5:00 PM. The facility notified the police immediately but was AWOL for 8 hours before being found.

2. Multiple incidents of the resident going AWOL are noted, but individual incidents are not documented. Items noted include being found on the freeway.

On 5/8/02, a review of resident 1's medical record revealed the following:

1. On 5/8/02, a review of the admission MDS (Minimum Data Set) assessment dated 8/14/01 indicated that the resident had problems with short and long term memory, moderately impaired cognitive skills (decisions poor, cues/supervision required). Indicators of delirium and disordered thinking were also documented including; easily distracted and periods of restlessness.

He was targeted as having difficulty with communication: "Sometimes understood [ability is limited to making concrete requests]", and "Sometimes understands-[responds adequately to simple, direct communication]".

He was noted to have indicators of anxiety by making

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 224	Continued From page 28	F 224		

"Repetitive questions-e.g., Where do I go? What do I do?". He also had verbally abusive behavior which occurred on 1 to 3 days in a week.

Resident 1 was also documented as being independent with walking. The assessment indicated that the resident had a legal guardian.

2. Review of the care plan for resident 1 on 5/8/02 indicated that he had a history of AWOL in a previous nursing facility. AWOL behaviors were addressed under Problem #2: "Alteration in behaviors related to worsening of chronic illness." The date the care plan was implemented was listed as the day of admission 8/7/01.

The dates that care plan problem #2 was reviewed and continued without change by the interdisciplinary team (IDT) were documented as: 8/16/01, 9/27/01, 11/8/01 1/31/02, 4/18/02 and 5/02/02.

The behaviors manifested by resident 1 were: "history of breaking down door and attempts to go AWOL at the last nursing facility the resident lived in. Resident would state 'call my dad, I want to go home".
Complications were listed as:
"1. Behavior that endangers the res. [resident]; [and,] 2. Diff. [difficulty] in dealing with people and coping in the facility".

Potential cause of the behavior was "prbs. [problems] associated with neurological disease". External factors were noted to be Psychotropic meds. [medications] and poor decision making ability due to traumatic brain injury and severe chronic cognitive deficit.

Care plan approaches for problem #2 were listed as:

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 224	Continued From page 29	F 224		

"(1). Doc. all AWOL attempts on data collection sheets on a 24 hr. basis.
(2). Monitor data collection sheets - report any changes to RN/DON [registered nurse/director of nurses].
(3). Monitor residents whereabouts frequently to decrease chances of AWOL.
(4). Provide reassurance/redirection as needed.
(5). If res. is successful in AWOL =
a. Search facility and grounds - announce on PA system.
b. Call police ASAP [as soon as possible].
c. Notify RN/DON or owner/Adm. [administrator]. also family &/or [and/or] guardian.
(6). See policy on AWOL.
(7). Use validation techniques to discuss with the resident the emotions behind attempts to leave facility.
(8). Assure res. is provided with ample physical activities.
(9). If tolerated place bell on w/c or shoe string so whereabouts can be readily determined."

The front sheet of Resident 1's care plan, which included the residents name and diagnoses, had a space on it where each resident's "LOA [leave of absence] PRIVILEGES" were documented. The blanks were checked indicating resident 1 could go out of the facility accompanied by family or staff. The space on the form which indicates a resident can leave "alone" was not marked.

An interview with the social service staff member was conducted on 5/10/02, at 2:30 PM. She indicated that this was the place staff would look to determine the leave privileges for individual residents.

3. On 5/8/02, a review of Resident 1's recertification of Physicians Orders for, 3/26/02 thru 5/26/02, documented the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 224	Continued From page 30	F 224		

Under the section titled "House Orders" that he "[May] go out on pass with [family, staff] [with] medications". The original order date was listed as 8/7/01, the date of his admission into the facility.

Under the section titled "Ancillaries/Information" the physician addressed the residents cognitive status: "It is my professional opinion that this resident [is not] capable of comprehending [his] rights and responsibilities. It is my professional opinion that this resident [is not] capable of participating in [his] plan of care and/or making medical decisions on [his] behalf."

4. Review of the nurse's progress notes on 5/8/02 documented several episodes of resident 1 leaving the facility on his own without the staff's knowledge.

A nurse's note dated 12/24/01, stated: "On occasion will go AWOL. seems to find way back to facility most of the time".

Other notes dated, 2/4/02 and 2/25/02, documented that the resident would go AWOL at times.

On 3/9/02, at 11:30 AM, a nurses note was written which stated: "Social Services [name] reports pt. was previously at [local grocery store] and fell. Small abrasion observed on right third finger et [and] elbow. Both arms cleaned et Band-Aid applied. Pt's wife called".

On 3/11/02, at 9:00 AM, a note was written which stated: "Pt AWOL family et [and] SLPD [Salt Lake City Police Department notified." On the same day, at 5:00 PM, eight hours after resident 1 was noted as missing, the nurse documented the following: "Pt. returned to facility - staff located pt. at SL [Salt Lake]

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 224	Continued From page 31 airport - pt. placed in NDU [New Dimensions Unit] - locked unit for more structured environment due to AWOL behavior - will cont. [continue] to monitor. Family notified". 5. Review of the social service progress notes on 5/8/02 revealed the following; On the day of admission 08/7/01, the social service staff member wrote the following: "Staff will monitor for possible AWOL &/or aggressive behaviors." On 8/16/01, the notes stated: "Resident is at risk for AWOL. He leaves the facility and wanting to go home". On 9/27/01, the notes stated: "No progress shown with decreasing risk at AWOL. Resident has several episodes of successfully going AWOL from facility. Police were notified of every incident and police have brought resident back to facility unharmed". She also indicated that the resident's "short term memory is very poor." On 11/08/01, the notes stated: "Resident has had several episodes of going AWOL from facility, because he wants to go home. Resident does wear a ID bracelet and has always been brought back by police safely. Signs have been posted at front door to prevent him from leaving the facility. Will cont. [continue] with approaches.....Resident has always been willing and cooperative with returning. Police have brought him back on several occasions". On 4/18/02, the notes stated: "Resident recently placed on NDU for structure environment due to going AWOL from facility numerous times. Poses himself to being a danger to self. Resident successfully made it to the airport and was brought back by the police.	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 224	Continued From page 32	F 224		

Resident is unaware of his surrounding and whereabouts".

6. Review of the behavior data collection sheets on 5/8/02 revealed the following episodes of AWOL:

2 during the month of January 2002,
2 in February 2002, 6 in March 2002, and
1 episode in April 2002 (after the resident was placed in the NDU).

7. Review of the Care Plan Conference Summaries completed on 5/8/02 documented the following:

Review of the Care Plan Conference Summary for 4/18/02, revealed that: "Patient placed on NDU due to ongoing AWOL episodes....Pt. will AWOL with outside NDU activity - activities must be in NDU [New Directions Unit]".

8. An interview was conducted with the director of nurses on 5/9/02 at 2:30 PM, regarding resident 1's AWOL behavior. He stated that the resident should not leave the facility without supervision due to his decreased cognition as well as short and long term memory loss.

9. On 5/10/02 at 2:00 PM, an interview was conducted with the manager of a local grocery store concerning Resident 1.

The manager stated that resident 1 would frequently come to the store. She stated that resident 1 would sit in a chair at the front of the store. She stated the resident 1 would crochet and wave to the people shopping in the store. She stated that resident 1 would remain at the store for "a long time".

When asked what the manager meant by "a long time",

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 224	Continued From page 33	F 224		

she stated from between 1 to 3 hours. She stated that she did not know how resident 1 got to and from the store, but had never seen any facility staff come and get resident 1 to return him to the facility.

10. Police reports were obtained and reviewed by the survey team on 5/13/02:

The report was dated 3/11/02 and documented the following: "The complainant reported that [resident 1]...left sometime around 0700 hrs [7:00 AM], and has not been seen since. [Resident 1] has severe brain damage...and cannot find his way back if he goes out. [Resident 1] has been known to go to the [name and address of local grocery store] but they haven't called today. I also checked [name and address of local gas station], but he hasn't been there today. They also know [resident 1]. [Resident 1 has a permanent wrist band with his name and the [facility's] phone # [number] on it.

...[Resident 1] has been picked up walking the freeway [in the past], trying to get home to [name of city]. [Resident 1's] [spouse] lives there. ATL [attempt to locate] and updated description entered...[Resident 1] was subsequently located...[resident 1] was returned...and turned over to [facility staff member's name], an employee."

RESIDENT 3

Resident 3 was admitted to the facility on 2/1/02 with diagnoses that include schizophrenia, alcohol abuse, seizure disorder, closed head injury, neurologic deficit and post traumatic stress disorder.

On 5/8/02 resident 3's medical record was reviewed and on 5/13/02 Salt Lake City Police Department reports were reviewed. Together they documented the

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 224	Continued From page 34	F 224		

following AWOL episode:

1. 5/3/02 at 9:00 AM to 5/9/02 when notified by resident 3's guardian that the resident would not be returning. Police were notified 5/4/02 at 9:00 AM. The resident was AWOL 24 hours before the police were notified and was missing for 6 days before he was located.

Review of resident 3's closed medical record on 5/8/02 revealed the following:

1. A physician's order dated 2/1/02 documented that resident 3 could have LOA privileges with staff only.

2. Review of the admission MDS, dated 4/25/02, documented that resident 3 had problems with short and long term memory and moderately impaired cognitive skills (decisions making poor, cues/supervision required). Indicators of delirium and disordered thinking were documented as easily distracted.

He was targeted as having difficulty with communication: Sometimes understands (responds adequately to simple, direct communication).

Resident 3 was documented as using a wheel chair for mobility.

3. Review of resident 3's comprehensive plan of care, undated, documented under problem 3, that resident 3 was an AWOL risk per previous history and cognitive impairment. The approach for this care plan problem included "3. Monitor residents whereabouts frequently to [decrease] chances of AWOL. 5. If resident is successful in AWOL; A. Search the facility & grounds; B. Call police ASAP (as soon as possible); C. Notify RN/DON or Admin. , also family and/or

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 224	Continued From page 35 guardian". 4. Review of the nurses notes revealed the following concerning resident 3: A nurses note, dated 5/3/02 at 9:00 AM, documented "resident left facility around 9:00 AM didn't sign out didn't tell any one where he was going or when he would be back...will inform next shift about resident being AWOL". A nurses note, dated 5/4/02 at 9:00 AM, 24 hours after the resident was noted missing, documented "Search made of facility still unable to find Pt. (patient). [Police] notified...". 5. During an interview with a social service representative, on 5/9/02 at 1:00 PM, she stated that resident 3's guardian called the facility on 5/9/02 stating that resident 3 had been located at his previous address in Idaho (6 days after resident 3 went AWOL). There was no documentation in resident 3's medical record to indicate that there was any further investigation by the facility to locate resident 3. 6. Review of a police report, dated 5/4/02, revealed the following documentation: The report documented that the incident regarding resident 3 occurred on 5/3/02 at 9:00 AM and was reported to the police on 5/4/02 at 8:57 AM (24 hours later). The report further documented, "The complainant [employee of the facility]...called to state that [resident 3] walked away Friday morning about 0900 [9:00 AM] 5-03-02. He [resident 3] just told the in charge nurse that he was leaving, no car involved....[Resident 3]...got about $70 from somewhere....complainant stated that he will likely return when [resident 3] runs out of money...."	F 224		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 224	Continued From page 36	F 224		

RESIDENT 4

Resident 4 was admitted to the facility on 1/29/02 with diagnoses that include dementia with depressive features and behaviors secondary to traumatic brain injury, hypertension, non-insulin dependant diabetes, prostate cancer, and colon cancer.

On 5/9/02 resident 4's medical record was reviewed and on 5/13/02 Salt Lake City Police Department reports were reviewed. Together they documented the following AWOL episode:

1. 3/12/02 at 7:25 PM to 3/12/02 at 8:45 PM in the NDU. Police were immediately called however, the facility failed to search the entire facility.

Review of resident 4's closed medical record on 5/9/02 revealed the following:

1. An admission physician's order, dated 1/29/02, documented resident 4 was to have LOA privileges with staff or family (not independently).

2. Resident 4 was admitted directly to the NDU on admission.

3. Review of the admission MDS dated 2/11/02 indicated that resident 4 had problems with short and long term memory, moderately impaired cognitive skills (decision making poor, cues/supervision required). Indicators of delirium and disordered thinking were documented as easily distracted.

He was targeted as having difficulty with communication: "sometimes understood (ability is limited to making concrete requests)", and "Sometimes understands (responds adequately to simple, direct

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

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F 224	Continued From page 37 communication)". Resident 4 had wandering behaviors that occurred 1 to 3 times in a week. He was also documented as being independent with walking. 4. Review of resident 4's plan of care, undated, documented under problem 3, that resident 4 was an "AWOL risk per previous history and cognitive impairment". The approach for this care plan problem included "3. Monitor residents whereabouts frequently to [decrease] chances of AWOL... 5. If resident is successful in AWOL; A. Search the facility & grounds; B. Call police ASAP; C. Notify RN/DON or Admin., also family and/or guardian". 5. Nursing notes documented that resident 4 was moved to the open unit on 3/1/02. 6. A nurses note, dated 3/12/02 at 7:25 PM, documented "CNA reported pt. is not in his room, search made of facility, unable to locate pt. in building. Unable to locate pt outside of bldg. (building) or surrounding area...Call placed to [police]...". At 7:50 PM the nurse documented that a police officer was in the facility. At 8:45 PM the nurse documented that resident 4 was found in the NDU and the police were notified. In an interview with the DON, on 5/14/02 at 1:45 PM, he stated that it was unknown how resident 4 got onto the NDU, but speculated that because the NDU is unlocked during meals, the resident could have gone in unnoticed after the evening meal. The DON also stated that he had done the initial search of the facility for resident 4 but failed to search the NDU before notifying the police.	F 224		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 224	Continued From page 38 7. On 5/14/02, a review of a police report, dated 3/12/02, revealed the following documentation: The report documented that the facility reported resident 4 missing on 3/12/02 at 7:32 PM. The report further documented, "Complainant [name on complainant-facility employee] reported [resident 4] missing at around 1930 hrs [7:30 PM]. [Complainant] stated [resident 4] left the Manor between 1800-1900 hrs [6:00 PM –7:00 PM]. [Complainant] stated they had checked the building and that [resident 4] was not there.... Before I had more police officers search for [resident 4] I asked nurse [name of nurse-employee 4] to double check the entire building, because I stated 'we need to be 100% sure he is not in the building' before we dedicated the manpower to the search. [Employee 4] and other nurses did check the building, but for some reason did not check the lock-down area. Six officers were dedicated to the search full-time.... An ATL (Attempt To Locate) was put out to every agency in Salt Lake County and others in Davis County. The Jails and Hospitals in the area were called. At one point I asked [employee 4] again to make sure they had checked every possible place in the building, and to regularly monitor the building in care [resident 4] returned through one of the doors. {Resident 4's} whole family was notified that [resident 4] was missing. At around 2140 hrs [9:40 PM] [employee 4] informed me that [resident 4] had been found in the lock-down area. No record was kept by the person who put him there and no one seemed to know how [resident 4] got there.... " "[Employee 4] obviously did not do a very thorough check of the building and did not seem to care about whether [resident 4] was found. Twice I had to interrupt [employee 4's] personal calls on the phone to	F 224		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 224	Continued From page 39	F 224		

get her to give me some assistance while the search was being conducted. ..."

"[Employee 1-charge nurse on duty] was very uncooperative, and at one point I had to ask him if he cared at all if [resident 4] was found. [Employee 1] did not seem to care and went about other business, refusing to give me assistance...."

INCIDENT OF POTENTIAL ABUSE BY A LICENSED NURSE

1. Review of a police report dated 3/12/02, obtained by the survey team on 5/13/02 revealed the following concerning allegations of neglect by a facility licensed charge nurse (Employee 1):

"I responded to the scene to set up an incident post on a missing person. I was advised that the nurse who was in charge [employee 1] was in the bathroom and had been for over one hour. [Employee 1] was supposed to be able to give us details about the missing person. I waited for approximately 30 minutes after I had arrived and then finally knocked on the door of the bathroom announcing myself and for [employee 1] to come out...."

"When [employee 1] came out he was excited, jumpy and could not stand still. His eyes were pin point and his behavior agitated. I felt he was on a controlled substance but could not determine what it was. I asked if [employee 1] was high and [employee 1] did not respond. I asked again and [employee 1] said that it was a free country and he could take anything he wanted.... After about ten minutes of [employee 1] walking around in an agitated state he began to look at patient folders. [Employee 1] would flip through the pages as fast as he could, making small notation in the folders. I wasn't sure what [employee 1] was noting

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 224	Continued From page 40	F 224		

since he insisted that he had just got to work, as if he had forgotten about the time he was in the bathroom."

"I spoke with the manager [survey note, Director of Nurses] of the complex and expressed my concerns. I told him that I felt that [employee 1] was possibly on a controlled substance judging from my experience. I offered to have a K9 search the area for any controlled substances. He contacted the administrator and opted to send [employee 1] home after conducting their own search.... "

"I expressed my concerns for the safety of the patients with [employee 1] in charge of them in the state of mind he was in."

"[Employee 1] did not show any concern for the missing person and did not assist us in any way until forced to stay in one area and talk to us. Also a note on his behavior. When his boss [name of boss], called on the telephone he said the police want to talk to you and then he hung up on his boss. [name of boss] had to call back."

The report continued with another police officer giving details of events the officer was involved in regarding employee 1:

"The complainant [name of complainant- employee of facility] left work shortly after reporting [resident 4] missing at 1930 hrs [7:30 PM] and not much information was passed to his replacement, [employee 1]. I came back about 10 minutes later after searching the immediate area and it was as though they had completely forgotten about [resident 4] ..."

"[Employee 1] was very uncooperative, and at one point I had to ask him if he cared at all if [resident 4] was found. He did not seem to care and went about

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 224	Continued From page 41	F 224		

other business, refusing to give me assistance..."

"I had to call [complainant] to come back to work as [employee 1] would not cooperate, and employee 1 was eventually asked to go home for the night when [complainant] arrived."

2. On 5/14/02 at 2:05 PM, in an interview with the facility DON and the social service (SS) staff member, the DON stated that he had been the one to call the police when resident 4 was found missing.

When asked if the police had voiced their concern regarding the safety of the residents due to the actions of employee 1, he stated he felt the police were more concerned with the fact that resident 4 was found inside the building than the safety of the residents due to the actions of employee 1.

When asked if they identified the actions of employee 1, on 3/12/02, during the time resident 4 was missing as possible neglect of residents, both the SS staff member and the DON stated that they had not recognized it as possible neglect.

The SS staff member stated that she did not know that she need to report alleged neglect in the same manner as she reported alleged abuse.

The DON was asked if employee 1 was sent home that evening as was implied in the police report. He stated that employee 1 was not sent home. The DON stated that he (the DON) had stayed at the facility until around midnight and observed the actions of employee 1. He stated that employee 1 was left alone in charge of the staff and residents from midnight until 6:00 AM the next morning.

When asked if the facility had conducted an

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 224	Continued From page 42 investigation into the possible neglect, the SS staff member stated that the facility had not investigated the allegations. The DON stated that employee 1 worked for the facility on an as needed basis, approximately 2 times a week. He stated that the facility continued to get complaints from the residents regarding employee 1's job performance after the 3/12/02 missing resident incident. The DON stated that he would come in to the facility periodically, while employee 1 was working, to check on employee 1's job performance. The SS staff member stated that because of the continued complaints from the residents, the administrator had decided that the facility should have employee 1 screened for controlled drugs. When asked if the facility had a copy of the drug screen, the SS staff member obtained a copy of the screen. The drug screen dated 3/20/02 (received by the facility on 3/22/02) showed positive results for 2 drugs. The SS staff member stated because of the positive drug screen, employee 1 was no longer working at the facility. Facility staff were requested to provide further information regarding the date of termination for employee 1. The drug screen for employee 1 was the only information provided therefore, surveyors were unable to determine exactly how many times employee 1 worked after the 3/12/02 police documented incident. 3. On 5/14/02, the facility's policy and procedure for "Abuse Reporting, Prevention, and investigation" was reviewed and revealed the following documentation:	F 224		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 224	Continued From page 43	F 224		

"Our facility will not permit residents to be subject to abuse by anyone, including staff..."

"Should any employee witness abuse (in any form) he or she is required to report it immediately. All reports of abuse must be reported to the Administrator, or Director of Nursing, or Social Services, who in turn will report it to the Administrator as well as to the resident's representative (sponsor), The State Survey and Certification Department, and Adult Protective Services or local law enforcement within twenty-four (24) hours of the occurrence in such incident. An immediate investigation will be conducted by the administrator and/or his Designee. The findings of such investigation be reported and faxed to the The State Survey and Certification Department, within five (5) working days of occurrence of such incidents...."

"When an allegation is staff to resident abuse, the employee will be placed on L.O.A. until investigation is complete."

The facility's Abuse Reporting, Prevention and Investigation Policy does not define what neglect is, or how the facility will identify, investigate or report incidents of neglect. Neglect is defined as failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.

4. On 5/14/02, a review of the contents of a facility in-service, dated 1/9/02, regarding "Review of abuse policy" revealed the following documentation:

"Definition of Abuse: A violation of the rights, dignity, and worth of individuals. Everything from passive abuse (ignoring someone who is dependent on you) to active abuse (hitting someone)... Examples of Types of Abuse...Passive Abuse: Abandonment or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

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F 224	Continued From page 44 neglect – Refusal or failure to fulfill a caretaking obligation such as provision of food or medical services..."	F 224		
F 225 SS=K	483.13(c)(1)(ii) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective	F 225	**F-225** **The reporting procedures utilized for residents 1, & 5 were reviewed and used in generic form for training. Their specific situations were discussed to help implement the overall plan that is attached.** **Residents 2, 3, 4, and 7 have been discharged.** 6/8/02 **All current residents' LOA requirements have been reviewed and updated. New Admissions will be reviewed by IDT team.** **Specified in the attached policy, which specifically states who, when, and under what circumstances a report and investigation will be made with regard to AWOL's, abuse and/or neglect, along with who the report should be made to and when has been implemented and attached. This is covered in our policy of "Abuse / Neglect Reporting..." This document gives definitions of various types of abuse,**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 225	Continued From page 45 action must be taken. This REQUIREMENT is not met as evidenced by: Based on review of medical records, staff interviews, review of facility incident reports, review of the facility's Abuse Reporting, Prevention and Investigation policy and Missing Patient Procedure, and review of the State Survey Agency records, it was determined the facility did not thoroughly investigate incidents of abuse or neglect regarding missing or AWOL (absent without leave) residents for 6 of 8 sample residents nor did they report the incidents or the results of their investigations to the State Survey agency and to other officials in accordance with state law through established procedures. Residents 1, 2, 3, 4, 5, 7. Findings include: 1. On 5/8/02, the facility's Abuse Reporting, Prevention and Investigation Policy was reviewed. It stated: "It is the policy of this facility that reports of abuse will be promptly reported and thoroughly investigated." (1.) "Our facility will not permit residents to be subjected to abuse by anyone, including staff members, other residents, consultants, volunteers, staff of other agencies serving the resident, family members, legal guardians, sponsors, friends, or other individuals." (2.) "To assist our facility in defining incidents of abuse, the following information is provided: A. Verbal abuse...B. Sexual abuse...C. Physical abuse...D. Involuntary seclusion is defined as separation of a resident from other residents or from	F 225	**reporting requirements, prevention, and the responsibility of who does the investigation within the facility. This training has been given in detail and completed.** **The inservices were held on May 11th; May 13th; May 14th, and May 15th. All personnel were included. The training was accomplished by the Administrator Nursing Administration and Social Services. Follow up training will be done for review of current employees, and orientation for new employees. The schedule for ongoing review of the policy and procedure is a mandatory employee meeting on the third Friday of each month.** **This plan of correction was reviewed by the Quality Assurance Committee on June 4, 2002. This plan will be monitored by the QA Committee not less than each quarter. However, the initial implementation will be reviewed by the independent consultant and included on his weekly review to insure, and provide documentation of compliance, and that an effective plan has been placed into affect.**	6/8/02

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 225	Continued From page 46 his or her room against the resident's will, or the will of the resident's legal guardian or representative (sponsor). E. Mental abuse..." (3.) "...All reports of abuse must be reported to the Administrator, or Director of Nursing, or Social Services, who in turn will report it to the Administrator as well as to the resident's representative (sponsor), The State Survey and Certification Department, and Adult Protective Services or local law enforcement within twenty-four (24) hours of the occurrence of such incident. An immediate investigation will be conducted by the Administrator and/or his Designee. The findings of such investigation will be reported and faxed to The State Survey and Certification Department, within five (5) working days of occurrence of such incidents." The facility's Abuse Reporting, Prevention and Investigation Policy does not define what neglect is, or how the facility will identify, investigate or report incidents of neglect. Neglect is defined as failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. 2. On 5/8/02, the facility's policy "Reporting of the Complaints to Program Certification" was reviewed. It stated the following: "The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported to the administrator of the facility and to other officials in accordance with the State law through established procedures including the State Survey and Certification agency..." 3. On 5/8/02, the facility's policy "Missing Patient Procedure" was reviewed. It stated the following:	F 225	**The Administrator has coordinated this effort with the Director of Nursing who will monitor the procedure and be responsible that this plan is followed. The director of nursing will make a follow up report at the Quarterly Quality Assurance Meetings. These reports will not only include that Policy and Procedure have been followed, but also any recommendations for improvement will be reviewed and implemented if warranted.** DON/IDT will meet weekly x 1 month then every month	6/8/02

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 225	Continued From page 47 "...(4.)..."The administrator and/or director are to travel to the facility and assume responsibility for the search, and notify outside agencies. If neither the administrator nor director can be contacted, the person in charge is to enlist the help of the outside agencies". "(5.) Notification of Agencies: a. Police... Police to be notified of patient missing 30 minutes. b. The family or other Responsible Persons...c. The Attending Physician. d. The Health Department..." 4. The survey team reviewed the medical records of residents identified as having AWOL behaviors. The findings are as follows: RESIDENT 2 Resident 2 was admitted to the facility on 5/31/01 with diagnoses of paranoid schizophrenia, cognitive disorder with behaviors, depression, suicidal ideations, insulin dependant diabetes, and polysubstance and alcohol abuse. Resident 2's medical record was reviewed on 5/7/02. 1. Review of the physician's orders revealed an order, dated 5/31/01 (the resident's admission date to the facility), stating the resident "May go out on pass with family, staff with medications." This indicated the resident was not to leave the facility unsupervised. 2. The nurse's notes were reviewed from 11/30/01 through 4/2/02. Documentation included the following: 1/6/02 at 6:00 PM: "Pt [patient] refused [medication]...took at 18:40 [6:40 PM] and then disappeared..." There was no documentation found to	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 225	Continued From page 48 evidence the facility attempted to locate resident 2 or notified the police when the resident disappeared. 1/7/02 at 7:30 AM: "Pt still AWOL ...Called [hospital] to inquire of Pt whereabouts. They said he left in a cab..." There was no documentation found to evidence the facility notified the police that the resident was AWOL after being released from the hospital. 3/6/02 from 1800 to 0600 [5:00 PM to 6:00 AM[: "Pt noted by CNA [certified nurse aide] to have left room and facility [without] signing out in LOA [leave of absence] book or informing staff. Social Worker office [Social Service representative] contacted [at] place of residence to inform her of event." The nurses note did not document the actual time the resident was determined to be AWOL or if the police had been notified. 3/7/02 at 6:30 AM: "Administrator notified and police notified...Police will call back facility later on this AM." There was no further documentation found to determine when the police returned the facility's call regarding resident being AWOL. 4/1/02 at 3:00 PM: "Pt has been gone since 0530 [5:30 AM]. Didn't sign out. Didn't report to this nurse. Still hasn't returned to facility..." There was no documentation that the police were notified that resident 2 was AWOL. 4/2/02 at 1:00 PM: "Put in a call to police department to report missing Pt. Waiting for officer to call back." This was 35 hours and 30 minutes after the facility documented resident 2 was AWOL. 3. On 5/13/02 a review of police reports, dated 3/7/02 and 4/2/02, revealed the following documentation:	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 225	Continued From page 49	F 225		

Police report dated 3/7/02: The report documented that the incident regarding resident 2 occurred on 3/6/02 at 11:55 PM and was reported to the police, by the facility, on 3/7/02 at 6:54 AM (7 hours later).

Police report dated 4/2/02: The report documented, "I was dispatched to the [facility] on a missing person case. I talked to the nurse who called the police. [Name of Nurse-employee 2] called the police after [resident 2] had been gone for a day and half. She stated [resident 2] has walked away from the facility in the past...We did not find [resident 2] in the building. I talked to [employee 3] who works at the facility. She said she saw [resident 2] yesterday morning at 0545 [5:45 AM]. He was [name of street] walking towards [name of street]. I asked [employee 2 and employee 3] why the police were not called then. [Employee 2] said because [resident 2] always leaves, but he always returns to get his meds.

4. Review of the State Survey Agency records evidenced there was no documentation that the facility had reported the AWOL incidents for resident 2 on 1/6/02, 3/6/02, and 4/1/02.

RESIDENT 5

Resident 5 was admitted to the facility on 8/15/00 with diagnoses of schizoaffective disorder bipolar type, insulin dependant diabetes mellitus and hypertension.

Resident 5's medical record was reviewed on 5/10/02.

1. Review of the current physician's orders revealed an order, dated 8/15/00, indicating the resident "May go out on pass with family, staff with medications" This order indicated the resident may not leave the facility without supervision.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 225	Continued From page 50	F 225		

2. The nurse's notes for resident 5 were reviewed and revealed the following:
11/26/01 at 5:00 AM: "Yesterday pt was LOA after lunch. Pt. didn't come back at present time." No specific time was documented for when the staff noted the resident was AWOL. There was no documentation that the police were notified when the staff determined the resident was AWOL.

11/27/01 at 7:30 AM: "Called and reported missing to police." This was approximately 44 hours after the resident went AWOL.

12/15/01 at 12:10 AM: "Pt up at nurse's desk, attempted to sign out in LOA book. Pt informed she could not sign out for LOA (at) this time. Pt again became belligerent, stating she was leaving facility. Pt informed she was not to leave facility + would be AWOL. Pt left the facility (at) this time.

12/15/01 at 12:35 AM: "Call placed to SLPD (Salt Lake Police Department) to report pt AWOL. Awaiting call back from SLPD for report to be made + case (number)."

12/15/01 at 2:00 AM: "Pt not back to facility, still awaiting call back from SLPD." There was no further documentation found that they received a call back from the police or called the police again to report the resident was AWOL.

3. On 5/13/02, a review of the police report, dated 11/27/01, revealed the following documentation:

The report documented the incident regarding resident 5 occurred on 11/25/01 at 11:30 AM and was reported to the police, by the facility, on 11/27/01 at 8:47 AM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 225	Continued From page 51	F 225		

When the police reports were reviewed there was no report found of a call from the facility on 12/15/01 at 12:35 AM, regarding resident 5 going AWOL.

4. Review of the State Survey Agency records evidenced there was no documentation that the facility had reported the AWOL incidents for resident 5 on 11/25/01 and 12/15/01.

RESIDENT 7

Resident 7 was admitted to the facility on 3/1/02 with diagnoses that included, dementia-Alzheimer's type with behaviors, Squamous cell carcinoma, diabetes mellitus, hypertension and anemia.

On 5/14/02, review of the medical record for resident 7 revealed the following documentation.

1. The nursing notes, dated 3/2/02, revealed the following documentation:

"0755 [7:55 AM] NDU [New Directions Unit] [residents and staff] came back upstairs [and] noticed that resident was not in the unit searched around the facility [and] up [and] down the block police notified [administrator] notified of resident taking off ss [social service] notified."

2. Review of the State Survey Agency records evidenced there was no documentation that the facility had reported the AWOL incident for resident 7 on 3/2/02.

RESIDENT 1

Resident 1 was a 42 year old male resident admitted on 8/7/01, with the following diagnoses: traumatic head injury, severe cognitive deficit with aggressive

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 225	Continued From page 52	F 225		

behaviors and aphasia (difficulty communicating).

On 5/8/02, a review of resident 1's medical record revealed the following:

1. A review of Resident 1's recertification of Physicians Orders for, 3/26/02 thru 5/26/02, documented the following:

Under the section titled "House Orders" that he "[May] go out on pass with [family, staff] [with] medications". The original order date was listed as 8/7/01, the date of his admission into the facility.

2. Review of the nurse's progress notes on documented several episodes of resident 1 leaving the facility on his own without the staff's knowledge.

A nurse's note dated 12/24/01, stated: "On occasion will go AWOL, seems to find way back to facility most of the time".

Other notes dated, 2/4/02 and 2/25/02, documented that the resident would go AWOL at times.

On 3/9/02, at 11:30 AM, a nurses note was written which stated: "Social Services [name] reports pt. was previously at [local grocery store] and fell. Small abrasion observed on right third finger et [and] elbow. Both arms cleaned et Band-Aid applied. Pt's wife called".

On 3/11/02, at 9:00 AM, a note was written which stated: "Pt AWOL family et [and] SLPD [Salt Lake City Police Department notified." On the same day, at 5:00 PM, eight hours after resident 1 was noted as missing, the nurse documented the following: "Pt. returned to facility - staff located pt. at SL [Salt Lake] airport - pt. placed in NDU - locked unit for more

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 225	Continued From page 53 structured environment due to AWOL behavior - will cont. [continue] to monitor. Family notified". 3. An interview was conducted with the director of nurses on 5/9/02 at 2:30 PM, regarding resident 1's AWOL behavior. He stated that the resident should not leave the facility without supervision due to his decreased cognition as well as short and long term memory loss. 4. Review of the State Survey Agency records evidenced there was no documentation that the facility had reported the AWOL incidents for resident 1 on 3/9/02 and 3/11/02 as required. RESIDENT 3 Resident 3 was admitted to the facility on 2/1/02 with diagnoses that included schizophrenia, alcohol abuse, seizure disorder, closed head injury, neurologic deficit and post traumatic stress disorder. Review of resident 3's closed medical record on 5/8/02 revealed the following: 1. A physician's order dated 2/1/02 documented that resident 3 could have LOA privileges with staff only. 2. A nurses note, dated 5/3/02 at 9:00 AM, documented "resident left facility around 9:00 AM didn't sign out didn't tell any one where he was going or when he would be back...will inform next shift about resident being AWOL". A nurses note, dated 5/4/02 at 9:00 AM, documented "Search made of facility still unable to find Pt. (patient). [Police] notified..." This was 24 hours after the resident had been identified as AWOL.	F 225		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 225	Continued From page 54 3. In an interview with a social service representative, on 5/9/02 at 1:00 PM, she stated that resident 3's guardian called the facility on 5/9/02 stating that resident 3 had been located at his previous address in Idaho (6 days after resident 3 went AWOL). There was no documentation in resident 3's medical record to indicate that there had been any further investigation by the facility to locate resident 3. There was no documentation found to indicate that the incident had been reported to the State Survey Agency. RESIDENT 4 Resident 4 was admitted to the facility on 1/29/02 with diagnoses that include dementia with depressive features and behaviors secondary to traumatic brain injury, hypertension, non-insulin dependant diabetes, prostate cancer, and colon cancer. Review of resident 4's closed medical record on 5/9/02 revealed the following: Resident 4 was admitted directly to the NDU on admission. Nursing notes documented that resident 4 was moved to the open unit on 3/1/02. 1. A nurses note, dated 3/12/02 at 7:25 PM, documented "CNA reported pt. is not in his room, search made of facility, unable to locate pt. in building. Unable to locate pt outside of bldg. (building) or surrounding area...Call placed to [police]...". At 7:50 PM the nurse documented that a police officer was in the facility. At 8:45 PM the nurse documented that resident 4 was found in the NDU and the police were notified. 2. On 5/14/02, a review of the police report, dated 3/12/02, regarding a missing resident, resident 4,	F 225		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 225	Continued From page 55	F 225		

revealed the following documentation:

"I responded to the scene to set up an incident post on a missing person. I was advised that the nurse who was in charge [employee 1] was in the bathroom and had been for over one hour. [Employee 1] was supposed to be able to give us details about the missing person. I waited for approximately 30 minutes after I had arrived and then finally knocked on the door of the bathroom announcing myself and for [employee 1] to come out....

When [employee 1] came out he was excited, jumpy and could not stand still. His eyes were pin point and his behavior agitated. I felt he was on a controlled substance but could not determine what it was. I asked if [employee 1] was high and [employee 1] did not respond. I asked again and [employee 1] said that it was a free country and he could take anything he wanted.... After about ten minutes of [employee 1] walking around in an agitated state he began to look at patient folders. [Employee 1] would flip through the pages as fast as he could, making small notation in the folders. I wasn't sure what [employee 1] was noting since he insisted that he had just got to work, as if he had forgotten about the time he was in the bathroom. I spoke with the manager of the complex and expressed my concerns. I told him that I felt that [employee 1] was possibly on a controlled substance judging from my experience. I offered to have a K9 search the area for any controlled substances. He contacted the administrator and opted to send [employee 1] home after conducting their own search.... I expressed my concerns for the safety of the patients with [employee 1] in charge of them in the state of mind he was in.

[Employee 1] did not show any concern for the missing person and did not assist is in any way until forced to stay in one area and talk to us. Also a note on his behavior. When his boss [name of boss], called

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 225	Continued From page 56	F 225		

on the telephone he said the police want to talk to you and then he hung up on his boss. [name of boss] had to call back."

The report continued with another police office giving details of events the officer was involved in regarding employee 1.
"The complainant [name of complainant- employee of facility] left work shortly after reporting [resident 4] missing at 1930 hrs [7:30 PM] and not much information was passed to his replacement, [employee 1]. I came back about 10 minutes later after searching the immediate area and it was as though they had completely forgotten about [resident 4] ...[Employee 1] was very uncooperative, and at one point I had to ask him if he cared at all if [resident 4] was found. He did not seem to care and went about other business, refusing to give me assistance...I had to call [complainant] to come back to work as [employee 1] would not cooperate, and employee 1 was eventually asked to go home for the night when [complainant] arrived.

3. On 5/14/02 at 2:05 PM, in an interview with the facility DON (Director of Nurses) and the social service (SS) staff member, the DON stated that he had been the one to call the police when resident 4 was found to be missing. When asked if the police had voiced their concern regarding the safety of the residents due to the actions of employee 1, he stated he felt they police were more concerned with the fact that resident 4 was found inside the building than the safety of the residents due to the actions of employee 1. When asked if they identified the actions of employee 1, on 3/12/02, during the time resident 4 was missing as possible neglect of residents, both the SS staff member and the DON stated that they had not recognized it as possible neglect. The SS staff member stated that she did not know that she need to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 225	Continued From page 57	F 225		

report alleged neglect in the same manner as she reported alleged abuse. The DON was asked if employee 1 was sent home that evening as was implied in the police report, he stated that employee one was not sent home. The DON stated that he (the DON) had stayed at the facility until around midnight and observed the actions of employee 1. The DON stated that he left the facility at around midnight. He stated that employee 1 was left alone in charge of the staff and residents from midnight until 6:00 AM the next morning.

When asked if the facility had conducted an investigation into the possible neglect, the SS staff member stated that the facility had not investigated the allegations.

The DON stated that employee 1 worked for the facility on an as needed basis, approximately 2 times a week. He stated that the facility continued to get complaints from the residents regarding employee 1's job performance after the 3/12/02 missing resident incident. The DON stated that he would come in to the facility periodically, while employee 1 was working, to check on employee 1's job performance. The SS staff member stated that because of the continued complaints from the residents the administrator had decided that the facility should have employee 1 screened for controlled drugs.

When asked if the facility had a copy of the drug screen, the SS staff member obtained a copy of the screen. The drug screen showed a positive results.

The SS staff member stated because of the positive drug screen, employee 1 was no longer working at the facility.

When the facility was advised, by police officers,

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 225	Continued From page 58 during an investigation of a missing facility resident, that the charge nurse on duty may have possibly neglected the residents of the facility, the facility failed to protect residents and investigate allegation of neglect. The facility charge nurse (employee 1) was identified by police officers as having behaviors of agitation and was possibly under the influence of a controlled substance. The facility was advised by the police officers that they were concerned for the safety of the facility residents. The facility failed to do an investigation into the allegations of possible neglect. The facility failed to report the alleged neglect to the State survey and certification agency and other officials in accordance with State law. 4. In an interview with the DON, on 5/8/02 at 1:45 PM regarding the facility protocol for reporting AWOL residents he stated "we search the facility and the grounds then notify the police if the resident is not found" The DON was asked how long they wait before notifying the police. He responded that it depends, if a resident forgets to sign out or if it is a resident who shouldn't be out. If the resident should not be out, we notify the police right away. When asked if a resident needs to be supervised when out of the facility the DON responded that a friend or family member would sign the resident out. 5. In an interview with the charge nurse, on 5/9/02 at 1:30 PM, concerning reporting of AWOL residents, she stated it would depend on the resident and if the resident was court committed or not, if court committed they would report the AWOL to the police immediately, or if a confused resident was AWOL, they would be reported to the police immediately, other wise they would wait 24 hours before notifying the police and then discharge the resident after 48 hours.	F 225		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 225	Continued From page 59 6. The DON was interviewed on 5/9/02 at 2:30 PM. The DON stated that the charge nurse should complete documentation of the investigation and reporting of all AWOL events in the residents medical record and also complete a facility incident report. When asked for the incident or investigation reports for the AWOL events for residents, the DON stated he was unable to locate any and stated the nurse must not have filled them out.	F 225		
F 226 SS=K	483.13(C)(1)(i) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. (Use F226 for deficiencies concerning the facility's development and implementation of policies and procedures.) This REQUIREMENT is not met as evidenced by: Based on medical record review, review of the facility's polices, and staff interview it was determined that the facility failed to develop and implement written policies and procedures that prohibited neglect for 6 of 8 residents with AWOL (absent without leave) behaviors. Residents: 1, 2, 3, 4, 5 and 7. Findings Include: On 55/8/02 the facility's "Abuse Reporting, Prevention and Investigation Policy" and "Missing Patient Procedure" was reviewed and stated: 1. Abuse Reporting, Prevention and Investigation:	F 226	**F-226** **Resident 1 has been assessed for appropriate placement on the NDU with the proper procedure having been followed and reviewed by the independent consultant. The NDU policy and procedure will be followed for continued review.** **Resident 2 has been discharged.** **Resident 3 has been discharged.** **Resident 4 has been discharged.** **Resident 5, who is not on the NDU has been evaluated and received new LOA requirements that are less restrictive. This was reviewed by Valley Mental Health, the QA Committee and the residents doctor.**	6/8/02

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 226	Continued From page 60 It is the policy of this facility that reports of abuse will be promptly reported and thoroughly investigated. Policy Interpretation and Implementation: (1.) Our facility will not permit residents to be subjected to abuse by anyone, including staff members, other residents, consultants, volunteers, staff of other agencies serving the resident, family members, legal guardians, sponsors, friends, or other individuals. (2.) To assist our facility in defining incidents of abuse, the following information is provided: A. Verbal abuse...B. Sexual abuse...C. Physical abuse...D. Involuntary seclusion is defined as separation of a resident from other residents or from his or her room against the resident's will, or the will of the resident's legal guardian or representative (sponsor). (Note: Temporary monitored separation from other residents will not be considered involuntary seclusion and may be permitted when used as a therapeutic intervention to reduce agitation as determined by the medical director , and/or director of nursing services, such as action that is consistent with the resident's plan of care.) E. Mental abuse... (3.) Should any employee witness abuse (in any form) he or she is required to report it immediately. All reports of abuse must be reported to the Administrator, or Director of Nursing, or Social Services, who in turn will report it to the Administrator as well as to the resident's representative (sponsor), The State Survey and Certification Department, and Adult Protective Services or local law enforcement within twenty-four (24) hours of the occurrence of such incident. An immediate investigation will be conducted by the Administrator and/or his Designee. The findings of such investigation be reported and faxed to The State Survey and Certification Department, within five (5) working days of occurrence of such incidents."	F 226	**Resident 7 has been discharged.** **All current residents' LOA requirements have been reviewed and updated. New Admissions will be reviewed by IDT team.** **To protect other current residents, and to have an ongoing plan that protects any new admissions the facility has implemented a new protocol and procedure to ensure that the location of residents are monitored and, that if missing or AWOL, a procedure to locate and report the situation. The attached policy and procedures have been implemented. Training of personnel and ongoing training for new personnel and review for current employees have been initiated. Specific inservices have been held and "spot" checks of employees demonstrating that they have learned and understand the training that has been given has been accomplished. All work shifts have been covered with regard to this training. A brief overview of the training includes: A time frame that each care giver or employee who is responsible for a**	6/8/02

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

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MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

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F 226	Continued From page 61 The facility's Abuse Reporting, Prevention and Investigation Policy does not define what neglect is, or how the facility will identify, investigate or report incidents of neglect. Neglect is defined as failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. 2. "Missing Patient Procedure" "(1.) Discovering that a Patient is Missing: Each nursing attendant is responsible for the whereabouts of her patients. No reasonable period of time should pass when the nursing attendant on duty does not know where all her patients are. If the nursing attendant is personally unable to locate any patient in her charge, the attendant is to notify her immediate supervisor...If the patient is not discovered within 10 to 15 minutes, an organized search effort is to be instigated... (3.) The Search: Time is a major factor in finding missing patients... Therefore it is important that missing patients be discovered soon, and that efforts be organized and thorough... (4.)...The administrator and/or director are to travel to the facility and assume responsibility for the search, and notify outside agencies. If neither the administrator not director can be contacted, the person in charge is to enlist the help of the outside agencies...(5.) Notification of Agencies: a. Police... Police to be notified of patient missing 30 minutes. b. The family or other Responsible Persons...c. The Attending Physician. d. The Health Department..." The survey team reviewed the medical records of residents identified as having AWOL behaviors. The findings are as follows: RESIDENT 2 Resident 2 was admitted to the facility on 5/31/01	F 226	resident initials that they have personally seen the resident. A copy of this form is attached. There is also a form that the employee signs that indicates the employee has received the training to accomplish the items listed above. A method that monitors residents who are on a leave of absence has been initiated. They are within a timeframe or will be placed on missing / AWOL status. The procedure covers who the employee reports the information that a resident is missing. The immediate follow up of looking for the resident, the time frame in which other agencies are to be notified and specific police reporting requirements are included. A procedure has been implemented so that agencies who received a report of a missing resident are contacted about the residents return and any pertinent data regarding the resident, such as physical condition, etc. This procedure was completed and implemented along with the inservice training. The information is attached. A specific agenda item will be included for discussion at the Quality Assurance Meetings. The effectiveness of these procedures will be reviewed, monitored, and revised if improvements are indicated or recommended.	6/8/02

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

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MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

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F 226	Continued From page 62 with diagnoses of paranoid schizophrenia, cognitive disorder with behaviors, depression, suicidal ideations, insulin dependant diabetes, and polysubstance and alcohol abuse. Resident 2's medical record was reviewed on 5/7/02 and documented the following: 1. The nurse's notes were reviewed for the time period of 5/31/01 through 4/2/02. Documentation included the following: 1/6/02 at 6:00 PM: "Pt [patient] refused [medication]...took at 18:40 [6:40 PM] and then disappeared..." There was no documentation found to evidence the facility attempted to locate resident 2 or notified the police when the resident disappeared. 1/7/02 at 7:30 AM: "Pt still AWOL [absent without leave]...Called [hospital] to inquire of Pt whereabouts. They said he left in a cab..." There was no documentation found to evidence the facility notified the police that the resident was AWOL after being released from the hospital. 3/6/02 from 1800 to 0600 (5:00 PM to 6:00 AM): "Pt noted by CNA [certified nurse aide] to have left room and facility [without] signing out in LOA [leave of absence] book or informing staff. Social Worker office [Social Service representative] contacted [at] place of residence to inform her of event." The nurses note did not document the actual time the resident was determined to be AWOL, if the facility staff had attempted to locate the resident, or if the police had been notified. 3/7/02 at 6:30 AM: "Administrator notified and police notified...Police will call back facility later on this AM." There was no further documentation found to	F 226	**Inservices on the above procedures were. given on May 11th; May 13th; May 14th; May 15th; & May 30th. All shifts, and all personnel received this inservice. The inservice was given by the Administrator and Social Services. Follow up training will be done for review of current employees, and orientation for new employees. The schedule for ongoing review of the policy and procedure is a mandatory employee meeting on the third Friday of each month.** **This will be monitored by the Director of Nursing and part of his report at the Quarterly Quality Assurance Meetings. However, the initial implementation of the plan was reviewed at a Quality Assurance Committee Meeting on June 4, 2002 to insure that viable plan had been placed into effect.** DON/IDT will monitor at weekly meetings x 1 month then monthly there after.	6/8/02

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 226	Continued From page 63	F 226		

determine when the police returned the facility's call regarding resident 2 being AWOL.

4/1/02 at 3:00 PM: "Pt has been gone since 0530 [5:30 AM]. Didn't sign out. Didn't report to this nurse. Still hasn't returned to facility..." There was no documentation found to evidence the facility staff attempted to locate resident 2 or notified the police that the pt was AWOL.

4/2/02 at 1:00 PM: "Put in a call to police department to report missing Pt. Waiting for officer to call back." This was 35 hours and 30 minutes after the facility documented resident 2 was AWOL.

2. On 5/13/02 a review of police reports, dated 3/7/02 and 4/2/02, Concerning Resident 2 was conducted revealing the following documentation:

Police report dated 3/7/02: The report documented that incident regarding resident 2 occurred on 3/6/02 at 11:55 PM and was reported to the police, by the facility, on 3/7/02 at 6:54 AM (7 hours later).

I talked to [employee 3] who works at the facility. She said she saw [resident 2] yesterday morning at 0545 [5:45 AM]. He was [name of street] walking towards [name of street]. I asked [employee 2 and employee 3] why the police were not called then. [Employee 2] said because [resident 2] always leaves, but he always returns to get his meds.

3. There was no documentation found in resident 2's medical record that the facility followed their Abuse Reporting, Prevention and Investigation policy or their Missing Patient policy. The facility failed to implement a search or notify the police in a timely manner when the resident was identified as being AWOL and did not notify the attending physician or

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 226	Continued From page 64	F 226		

the State agency.

RESIDENT 5

Resident 5 was admitted to the facility on 8/15/00 with diagnoses of schizoaffective disorder bipolar type, insulin dependant diabetes mellitus and hypertension.

The resident's medical record was reviewed on 5/10/02.

1. The nurse's notes for resident 5 were reviewed and revealed the following:

11/26/01 at 5:00 AM: "Yesterday pt was LOA after lunch. Pt. didn't come back at present time. Does not take 11/25/01 noc (night time) meds." No specific time was documented for when the staff noted the resident was AWOL. There was no documentation found regarding the staff attempting to locate the resident or that the police were notified when the staff determined the resident was AWOL.

11/27/01 at 7:30 AM: "Called and reported missing to police." This was approximately 44 hours after the resident went AWOL.

12/15/01 at 12:10 AM: "Pt up at nurse's desk, attempted to sign out in LOA book. Pt informed she could not sign out for LOA (at) this time. Pt again became belligerent, stating she was leaving facility. Pt informed she was not to leave facility + would be AWOL. Pt left the facility (at) this time.

12/15/01 at 12:35 AM: "Call placed to SLPD (Salt Lake Police Department) to report pt AWOL.

2. Review of a police report on 5/13/02 documented the following incident:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 226	Continued From page 65 The report which was dated 11/27/01, documented that the incident regarding resident 5 occurred on 11/25/01 at 11:30 AM, and was reported by the facility to the police two days later, on 11/27/01 at 8:47 AM. 3. There was no documentation found in resident 5's medical record that the facility followed their Abuse Reporting, Prevention and Investigation policy or their Missing Patient policy. The facility failed to implement a search or notify the police in a timely manner when the resident was identified as being AWOL and did not notify the attending physician or the State agency. RESIDENT 1 Resident 1 was a 42 year old male resident admitted on 8/7/01, with the following diagnoses: traumatic head injury, severe cognitive deficit with aggressive behaviors and aphasia (difficulty communicating). 1. Review of the nurse's progress notes on 5/8/02 documented several episodes of resident 1 leaving the facility on his own without the staff's knowledge. A nurse's note dated 12/24/01, stated: "On occasion will go AWOL, seems to find way back to facility most of the time". Other notes dated, 2/4/02 and 2/25/02, documented that the resident would go AWOL at times. On 3/9/02, at 11:30 AM, a nurses note was written which stated: "Social Services [name] reports pt. was previously at [local grocery store] and fell. Small abrasion observed on right third finger et [and] elbow. Both arms cleaned et Band-Aid applied. Pt's wife called".	F 226		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 226	Continued From page 66	F 226		

On 3/11/02, at 9:00 AM, a note was written which stated: "Pt AWOL family et [and] SLPD [Salt Lake City Police Department notified." On the same day, at 5:00 PM, eight hours after resident 1 was noted as missing, the nurse documented the following: "Pt. returned to facility - staff located pt. at SL [Salt Lake] airport - pt. placed in NDU [New Dimensions Unit] - locked unit for more structured environment due to AWOL behavior - will cont. [continue] to monitor. Family notified".

2. Review of the social service progress notes on 5/8/02 revealed the following;

On the day of admission 08/7/01, the social service staff member wrote the following: "Staff will monitor for possible AWOL &/or aggressive behaviors."

On 4/18/02, the notes stated: "Resident recently placed on NDU for structure environment due to going AWOL from facility numerous times. Poses himself to being a danger to self. Resident successfully made it to the airport and was brought back by the police. Resident is unaware of his surrounding and whereabouts".

3. Review of the behavior data collection sheets on 5/8/02 revealed the following episodes of AWOL:

2 during the month of January 2002,
2 in February 2002, 6 in March 2002, and
1 episode in April 2002 (after the resident was placed in the NDU.

4. Review of the Care Plan Conference Summaries completed on 5/8/02 documented the following:

Review of the Care Plan Conference Summary for

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 226	Continued From page 67 4/18/02, revealed that: "Patient placed on NDU due to ongoing AWOL episodes....Pt. will AWOL with outside NDU activity - activities must be in NDU". 5. An interview was conducted with the director of nurses on 5/9/02 at 2:30 PM, regarding resident 1's AWOL behavior. He stated that the resident should not leave the facility without supervision due to his decreased cognition as well as short and long term memory loss. 6. On 5/10/02 at 2:00 PM, an interview was conducted with the manager of a local grocery store concerning Resident 1. The manager stated that resident 1 would frequently come to the store. She stated that resident 1 would sit in a chair at the front of the store. She stated the resident 1 would crochet and wave to the people shopping in the store. She stated that resident 1 would remain at the store for "a long time". When asked what the manager meant by "a long time", she stated from between 1 to 3 hours. She stated that she did not know how resident 1 got to and from the store, but had never seen any facility staff come and get resident 1 to return him to the facility. 7. Police reports were obtained and reviewed by the survey team on 5/13/02: The report was dated 3/11/02 and documented the following: "The complainant reported that [resident 1]...left sometime around 0700 hrs [7:00 AM], and has not been seen since. [Resident 1] has severe brain damage...and cannot find his way back if he goes out. [Resident 1] has been known to go to the [name and address of local grocery store] but they haven't called today. I also checked [name and address of local gas	F 226		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 226	Continued From page 68	F 226		

station], but he hasn't been there today. They also know [resident 1]. [Resident 1 has a permanent wrist band with his name and the [facility's] phone # [number] on it.

...[Resident 1 has been picked up walking the freeway [in the past], trying to get home to [name of city]. [Resident 1's] [spouse] lives there. ATL [attempt to locate] and updated description entered...[Resident 1] was subsequently located...[resident 1] was returned...and turned over to [facility staff member's name], an employee."

8. Review of the Utah States Agency records evidenced there was no documentation that the facility had reported the AWOL incidents for resident 1 which were documented in the nurse's notes on 3/09/02 and 3/11/02. The behavior data collection sheets noted 2 AWOL's in January 2002, 2 in February 2002, 6 in March 2002, and 1 episode in April 2002 (after the resident was placed in the NDU). Details of the incidents documented on the behavior data sheets were not documented further in the nurses or social services notes.

9. The facility failed to follow their abuse reporting and investigation policy by not reporting to the "State Survey and Certification Department within twenty-four (24) hours of the occurrence of such incident". There was no documentation of a thorough investigation of all AWOL resident 1's frequent unsupervised visits to a local grocery store. The nursing attendants were not aware of resident 1's whereabouts at all times as was outlined as their responsibility in the policy.

RESIDENT 3

Resident 3 was admitted to the facility on 2/1/02 with

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 226	Continued From page 69	F 226		

diagnoses that included schizophrenia, alcohol abuse, seizure disorder, closed head injury, neurologic deficit and post traumatic stress disorder.

Review of resident 3's closed medical record on 5/8/02 revealed the following:

1. A physician's order dated 2/1/02 documented that resident 3 could have LOA privileges with staff only.

2. Review of Resident 3's admission MDS, dated 4/25/02, documented that resident 3 had problems with short and long term memory and moderately impaired cognitive skills (decisions making poor, cues/supervision required). Indicators of delirium and disordered thinking.

3. A nurses note, dated 5/3/02 at 9:00 AM, documented "resident left facility around 9:00 AM didn't sign out didn't tell any one where he was going or when he would be back...will inform next shift about resident being AWOL".

A nurses note, dated 5/4/02 at 9:00 AM, 24 hours after the resident was noted missing, documented "Search made of facility still unable to find Pt. [Police] notified...".

4. In an interview with a social service representative, on 5/9/02 at 1:00 PM, she stated that resident 3's guardian called the facility on 5/9/02 stating that resident 3 had been located at his previous address in Idaho (6 days after resident 3 went AWOL).

5. The facility's Abuse Reporting , Prevention and Investigation Policy did not define what was neglect (residents not provided supervision and leaving the facility unattended). Resident 3's AWOL incident was not reported to the State Survey And Certification

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 226	Continued From page 70 Agency as potential neglect. 6. The facility failed to follow their "Missing Patient Procedure" The staff was unaware of the resident 3's whereabouts at all times and when the resident was found missing, did not conduct an immediate and thorough search of the facility and neighborhood. The administrator and or director of nursing did not travel to the facility and assume responsibility for the search and notify outside agencies including the police and the health department. RESIDENT 4 Resident 4 was admitted to the facility on 1/29/02 with diagnoses that included dementia with depressive features and behaviors secondary to traumatic brain injury, hypertension, non-insulin dependant diabetes, prostate cancer, and colon cancer. Review of resident 4's closed medical record on 5/9/02 revealed the following: 1. An admission physician's order, dated 1/29/02, documented resident 4 was to have LOA privileges with staff or family (not independently). 2. Resident 4 was admitted directly to the NDU on admission. Nursing notes documented that resident 4 was to move to the open unit on 3/1/02. 3. A nurses note, dated 3/12/02 at 7:25 PM, documented "CNA reported pt. is not in his room, search made of facility, unable to locate pt. in building. Unable to locate pt outside of bldg. (building) or surrounding area...Call placed to [police]...". At 7:50 PM the nurse documented that a police officer was in the facility; at 8:45 PM the nurse documented that resident 4 was found in the NDU.	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 226	Continued From page 71	F 226		

4. A police report documented the following: "Complainant [name on complainant-facility employee] reported [resident 4] missing at around 1930 hrs [7:30 PM]. [Complainant] stated [resident 4] left the Manor between 1800-1900 hrs [6:00 PM –7:00 PM]. [Complainant] stated they had checked the building and that [resident 4] was not there.... Before I had more police officers search for [resident 4] I asked nurse [name of nurse-employee 4] to double check the entire building, because I stated 'we need to be 100% sure he is not in the building' before we dedicated the manpower to the search. [Employee 4] and other nurses did check the building, but for some reason did not check the lock-down area. Six officers were dedicated to the search full-time.... At one point I asked [employee 4] again to make sure they had checked every possible place in the building, and to regularly monitor the building in care [resident 4] returned through one of the doors.... At around 2140 hrs [9:40 PM] [employee 4] informed me that [resident 4] had been found in the lock-down area. No record was kept by the person who put him there and no one seemed to know how [resident 4] got there.... "

"[Employee 4] obviously did not do a very thorough check of the building and did not seem to care about whether [resident 4] was found. Twice I had to interrupt [employee 4's] personal calls on the phone to get her to give me some assistance while the search was being conducted. ..."

"[Employee 1-charge nurse on duty] was very uncooperative, and at one point I had to ask him if he cared at all if [resident 4] was found. [Employee 1] did not seem to care and went about other business, refusing to give me assistance...."

5. In an interview with the DON, on 5/14/02 at 1:45

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 226	Continued From page 72 PM, he stated that it was unknown how resident 4 got onto the NDU, but speculated that because the NDU is unlocked during meals, resident 4 could have gone in unnoticed after the evening meal. The DON also stated that he had done the initial search of the facility for resident 4 but failed to search the NDU before notifying the police. 6. The facility failed to follow their "Missing Patient Procedure" by not conducting a thorough search of the facility (the NDU was not searched) when resident 4 was found missing. RESIDENT 7 Resident 7 was admitted to the facility on 3/1/02 with diagnoses that included, dementia-Alzheimer's type with behaviors, Squamous cell carcinoma, diabetes mellitus, hypertension and anemia. Review of the medical record for resident 7 on 5/14/02, revealed the following: 1. Review of the "Order for Commitment and/or Detention Pending Hearing and/or Examination" papers, dated 3/1/02, documented, "...Patient is demented, took off from a nursing home in Salt Lake City and was found in Provo 2 days later. Patient has no insight into his illness. He is Mentally ill and danger to himself." 2. The nursing notes, dated 3/2/02, revealed the following documentation: "0755 [7:55 AM] NDU [residents and staff] came back upstairs [and] noticed that resident was not in the unit searched around the facility [and] up [and] down the block police notified [administrator] notified of resident taking off ss [social service] notified."	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 226	Continued From page 73	F 226		

"1100 [11:00 AM] [hospital] called [and] stated that they had [resident 7] [and] that they would be bringing him back ..."

3. Review of the State Survey Agency records evidenced there was no documentation that the facility had reported the AWOL incident for resident 7 on 3/2/02, as mandated by policy.

4. The facility failed to follow their "Missing Patient Procedure" by not monitoring resident 7's whereabouts and he left the facility unattended. The facility did not notify the state agency that the resident was missing.

INCIDENT OF POTENTIAL ABUSE BY A LICENSED NURSE

1. Review of a police report dated 3/12/02, obtained by the survey team on 5/13/02 revealed the following concerning allegations of neglect by a facility licensed charge nurse (Employee 1):

"I responded to the scene to set up an incident post on a missing person. I was advised that the nurse who was in charge [employee 1] was in the bathroom and had been for over one hour. [Employee 1] was supposed to be able to give us details about the missing person. I waited for approximately 30 minutes after I had arrived and then finally knocked on the door of the bathroom announcing myself and for [employee 1] to come out...."

"When [employee 1] came out he was excited, jumpy and could not stand still. His eyes were pin point and his behavior agitated. I felt he was on a controlled substance but could not determine what it was. I asked if [employee 1] was high and [employee 1] did not

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 226	Continued From page 74	F 226		

respond. I asked again and [employee 1] said that it was a free country and he could take anything he wanted.... After about ten minutes of [employee 1] walking around in an agitated state he began to look at patient folders. [Employee 1] would flip through the pages as fast as he could, making small notation in the folders. I wasn't sure what [employee 1] was noting since he insisted that he had just got to work, as if he had forgotten about the time he was in the bathroom."

"I spoke with the manager [survey note, Director of Nurses] of the complex and expressed my concerns. I told him that I felt that [employee 1] was possibly on a controlled substance judging from my experience. I offered to have a PK2 search the area for any controlled substances. He contacted the administrator and opted to send [employee 1] home after conducting their own search.... "

"I expressed my concerns for the safety of the patients with [employee 1] in charge of them in the state of mind he was in."

"[Employee 1] did not show any concern for the missing person and did not assist us in any way until forced to stay in one area and talk to us. Also a note on his behavior. When his boss [name of boss], called on the telephone he said the police want to talk to you and then he hung up on his boss. [name of boss] had to call back."

The report continued with another police officer giving details of events the officer was involved in regarding employee 1:

"The complainant [name of complainant- employee of facility] left work shortly after reporting [resident 4] missing at 1930 hrs [7:30 PM] and not much information was passed to his replacement, [employee

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 226	Continued From page 75	F 226		

1]. I came back about 10 minutes later after searching the immediate area and it was as though they had completely forgotten about [resident 4] ..."

"[Employee 1] was very uncooperative, and at one point I had to ask him if he cared at all if [resident 4] was found. He did not seem to care and went about other business, refusing to give me assistance..."

"I had to call [complainant] to come back to work as [employee 1] would not cooperate, and employee 1 was eventually asked to go home for the night when [complainant] arrived."

2. On 5/14/02 at 2:05 PM, in an interview with the facility DON and the social service (SS) staff member, the DON stated that he had been the one to call the police when resident 4 was found missing.

When asked if the police had voiced their concern regarding the safety of the residents due to the actions of employee 1, he stated he felt the police were more concerned with the fact that resident 4 was found inside the building than the safety of the residents due to the actions of employee 1.

When asked if they identified the actions of employee 1, on 3/12/02, during the time resident 4 was missing as possible neglect of residents, both the SS (social service) staff member and the DON stated that they had not recognized it as possible neglect.

The SS staff member stated that she did not know that she need to report alleged neglect in the same manner as she reported alleged abuse.

The DON was asked if employee 1 was sent home that evening as was implied in the police report. He stated that employee 1 was not sent home. The DON stated

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 226	Continued From page 76	F 226		

that he (the DON) had stayed at the facility until around midnight and observed the actions of employee 1. He stated that employee 1 was left alone in charge of the staff and residents from midnight until 6:00 AM the next morning.

When asked if the facility had conducted an investigation into the possible neglect, the SS staff member stated that the facility had not investigated the allegations.

The DON stated that employee 1 worked for the facility on an as needed basis, approximately 2 times a week. He stated that the facility continued to get complaints from the residents regarding employee 1's job performance after the 3/12/02 missing resident incident.

The DON stated that he would come in to the facility periodically, while employee 1 was working, to check on employee 1's job performance. The SS staff member stated that because of the continued complaints from the residents, the administrator had decided that the facility should have employee 1 screened for controlled drugs.

When asked if the facility had a copy of the drug screen, the SS staff member obtained a copy of the screen. The drug screen dated 3/20/02 (received by the facility on 3/22/02) showed positive results for 2 drugs.

The SS staff member stated because of the positive drug screen, employee 1 was no longer working at the facility. Facility staff were requested to provide further information regarding the date of termination for employee 1. The drug screen for employee 1 was the only information provided therefore, surveyors were unable to determine exactly how many times

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 226	Continued From page 77 employee 1 worked after the 3/12/02 police documented incident. 3. The facility failed to to follow their abuse reporting and investigation policy by allowing employee 1 to continue working after questions from the police and other sources concerning his ability to function: "Our facility will not permit residents to be subject to abuse by anyone, including staff..." The facility did not follow their policy of reporting abuse (neglect) to the State Survey and Certification agency within 24 hours of the incident. An immediate investigation was not conducted by the administrator or his designee. Employee 1 was not... "placed on L.O.A. until investigation is complete." Employee 1 (the facility charge nurse) was allowed to work the remainder of his shift after being monitored by the director of nurses for a few hours. He was allowed to work more shifts with occasional monitoring by the director of nurses until he was finally drug tested and dismissed. 4. The facility's Abuse Reporting, Prevention and Investigation Policy does not define what neglect is, or how the facility will identify, investigate or report incidents of neglect. The staff were not aware that the above incident constituted abuse via neglect so did not report and investigate it as such.	F 226		
F 280 SS=F	483.20(k)(2) RESIDENT ASSESSMENT 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	F 280		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 280	Continued From page 78 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. This REQUIREMENT is not met as evidenced by: Based on review of the medical records, review of the IDT (Interdisciplinary Team) meeting minutes, and staff interviews it was determined that the facility did not evaluate or revise the care plans for 6 of 8 residents as the resident's status changed. Residents 1, 2, 3, 4, 5 and 7. Findings include: RESIDENT 2 Resident 2 was admitted to the facility on 5/31/01 with diagnoses of paranoid schizophrenia, cognitive disorder with behaviors, depression, suicidal ideations, insulin dependant diabetes, and polysubstance and alcohol abuse. Resident 2's medical record was reviewed on 5/7/02. 1. Review of the physician's orders from admission on 5/31/01 through 5/7/02 evidenced no documentation that the physician gave orders for the resident to be placed in the NDU (New Directions Unit). 2. Review of the facility's contract agreement with resident 2, dated 6/13/01, indicated the following: "I [resident 2], enter into this agreement with [the facility]. I understand I will:	F 280	**F-280** **Residents' 1 and 5 care plans has been updated to reflect resident needs and status.** **Resident 2, 3, 4, and 7 have been discharged.** **To insure that the corrective measures are on going for current and new residents the facility will follow the directed plan of correction regarding an independent consultant.** **An additional consultant, approved by the State, will be hired and directly assigned to review the procedures we have installed for effectiveness. This consultant will also be asked to make sure that the on going review and assessment of the procedures will be effective now and in the future. The recommendations of the consultant will be included in our overall plan and initiated as indicated. This consultant will review and/or develop resident assessment and behavior management plans to insure they are adequate and effective. The consultant will submit weekly reports to the facility**	6/8/02

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

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F 280	Continued From page 79 (1). I will have my money's managed through [mental health caseworker]. (2). Not use illegal drugs or alcohol. (3). Agree to attend drug and alcohol groups through [outpatient mental health]. (4). Agree to have urine and /or blood drug screen tests done on a monthly basis and /or at the staffs discretion. (5). Go to Social Services or RN [registered nurse]/DON [Director of Nursing] when I feel depressed, sad, have pressure from other residents, or have need/desire to do illegal drugs or alcohol. Upon completion of the above I will be allowed to go into the community on a daily basis. If I do not comply with the above, I will voluntarily place myself on the locked unit for self protection." This form was signed by resident 2, the Social Service representatives, and the Social worker on 6/13/01. The physician did not sign this form. There was no further documentation found in the resident's medical record to evidence the physician was involved in developing the facility's contract agreement with resident 2. 3. The mental health physician's notes, dated 1/24/02, stated "...On 12/26/01, [resident 2] was put on the closed/locked unit due to his repeated calls to 911. " 4. The IDT (Interdisciplinary Team) meeting minutes were reviewed for the dates of 5/31/01 through 4/2/02. No documentation was found to evidence resident 2's attending physician was an active member of the IDT team. Documentation of the IDT meeting for the date 2/21/02 indicated the following:	F 280	**indicating the findings and progress of his/her review. These findings and recommendations will be incorporated in the Quality Assessment and Assurance Committees. Changes in Policy and procedures will be made if indicated. A copy of these weekly consultant reports will be forwarded to the State on a weekly basis.** **The initial review by the consultant indicated that specific areas requiring direction from the consultant are:** **Make use of the current alarm system.** **Functional Analysis needs to be completed and used in development of new behavior management plans.** **Data collection methods should include qualitative information.** **Maladaptive Behavior needs to be specifically stated and described in the care plans.**	6/8/02

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 280	Continued From page 80 "... Plan of Care: Nursing...Placed on NDU [secondary to] phone calls made to emerg. [emergency] services...Summary of Care Plan Conference Discussion. Pt moved out of NDU in Feb. [February] [with] 1 episode noted of inapp. [inappropriate] phone use. Will monitor for cont. [continued] episodes. Pt informed if episodes cont. [continue] he will be placed on NDU again." There was no documentation found in the IDT meetings regarding the specific dates of when resident 2 was placed in the NDU or when he was released from the NDU. There was no documentation found to evidence the IDT meetings included resident 2's physician in the decision to place the resident in the NDU. The IDT also did not document that they identified resident 2's AWOL behaviors as a problem that required an intervention. 5. The nurse's notes were reviewed from 5/31/01 through 4/2/02. Documentation included the following: 12/25/01 at 5:45 PM: "Pt [patient] came up to nurses station and said he just called the paramedics. I asked why and he said he was hearing voices to kill himself." 12/26/01 at 12:15 AM: "Pt back to facility from[hospital] ER [emergency room] via cab..." There was no documentation found in the nurse's notes that resident 2 was placed in the NDU, as per the mental health physician's documentation on 1/24/02. The first nurse's note to document that resident 2 was residing in the NDU was: 1/17/02 at 9:30 AM: "...Amb. [ambulating] ad lib [at liberty] in NDU ..." 1/6/02 at 6:00 PM: "Pt refused (medication)...took at 18:40 (6:40 PM) and then disappeared...Police officer	F 280	**Include more components in the behavior management plans. Purpose of Plan, baseline data, etc. as trained to the IDT team by the consultants.** **Document dates of review and/or revision.** **Inservice regarding data collection and philosophy of psotive behavior management.** **Have Quality Assurance meetings weekly, and have resident attend when appropriate.** **Keep documentation of meeting for review.** 6/8/02 **Consultants will complete an inservise on the above behavior management information and demonstrate the proper techniques of functional analysis.** **The facility will follow the quidelines and inservice training provided by the consultants to ensure that the problem is solved for all current and new residents.**	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 280	Continued From page 81	F 280		

came into the facility, he stated (resident 2) got a crime number...because he tried to do a suicide in the middle of the road....(the patient was taken to the hospital by the police)...Will continue to monitor."

1/7/02 at 10:45 AM: "Pt returned to facility..."

3/6/02 from 1800 to 0600 (5:00 PM to 6:00 AM): "Pt noted by CNA (certified nurse aide) to have left room and facility (without) signing out in LOA (leave of absence) book or informing staff.

3/8/02 at 3:00 PM: "Pt returned to facility via staff assisted from hospital stay."

3/29/02 at 5:00 PM: "Police came to desk and stated [resident 2] called and said that [another resident] was following him all over the facility and threatening him [with] a knife - pt. did not notify any of the staff. Story not substantiated by any witnesses, staff or residents...pt. placed in NDU for more structured environment/supervision."

4/1/02 at 3:00 PM: "Pt has been gone since 0530 (5:30 AM). Didn't sign out. Didn't report to this nurse. Still hasn't returned to facility..."

6. Review of resident 2's Plan of Care, dated 6/13/01, evidenced the following:

"Problem #1: Alteration in behavior r/t [related to] worsening of chronic illness....Approach:...7. Res. [resident] is not to leave facility unsupervised [without] staff or [without] approval from IDT."

There was no documentation found to evidence resident 2's Plan of Care had been reviewed and updated regarding the resident's AWOL behaviors, inappropriate phone use, and placement on the NDU.

The Administrator has coordinated this effort with the Director of Nursing who will monitor the procedure and be responsible that this plan is followed. The director of nursing will make a follow up report at the Quarterly Quality Assurance Meetings. These reports will not only include that Policy and Procedure have been followed, but also any recommendations for implovement will be reviewed and implemented if warranted.

6/8/02

Care plans will be updated as Needed ~~as~~ well as quarterly. The changes will be made in IDT meeting weekly x 1 month then monthly.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 280	Continued From page 82	F 280		

RESIDENT 5

Resident 5 was admitted to the facility on 8/15/00 with diagnoses of schizoaffective disorder bipolar type, insulin dependant diabetes mellitus and hypertension.

The resident's medical record was reviewed on 5/10/02.

1. Review of the current physician's orders revealed an order, dated 8/15/00, indicating the resident "May go out on pass with family, staff with medications" This order indicated the resident must not leave the facility without supervision.

2. Review of resident 5's Plan of Care, dated 8/25/00, evidenced the following:

Problem #1: "Alteration in Behavior: Elopement risk... m/b(manifested by) Res.(resident) leaves the facility without notifying nursing or signing out. Complicated by: 1. Behavior that endangers the res...External factors: 1. Poor decision making ability. 2. Schizoaffective disorder."
Goals: "Res. will [decrease] risk for elopement as evident by notify nursing + signing out prior to any LOA [leave of absence] thru next review."
Approach: "...5. Staff will inform [social services] +/or Admin. [administrator] if res. leaves the facility [without] signing out. 6. Discuss [with] the res. in private after any incidents occur + strongly reinforce compliance [with] facility rules [such as always informing staff + signing out]."

Documentation on the resident's Plan of Care evidenced it had been reviewed on 10/5/00, 11/16/00, 2/8/01, 10/18/01, and 1/10/02. There was no evidence found that the Plan of Care for this problem had been

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 280	Continued From page 83 updated or changed by the facility staff for these dates. 3. Review of the Social Service Progress Record, dated 1/10/02, indicated "Resident conts. [continues] to periodically, when she becomes upset, take off without signing out or letting nursing or anyone know that she is leaving and without medications will be gone 2 or 3 days. Staff have had to call police to notify that she is missing." 4. Review of the IDT care plan conference forms revealed the following: 1/10/02: "Care Plan Element...Risks/consequences: Ongoing AWOL'S...Summary of Care Plan Conference Discussion: Multi (multiple) episodes of AWOL ongoing..." 3/28/02: "Care Plan Element...Risks/consequences: Ongoing AWOL..." 5. The nurse's notes for resident 5 were reviewed and revealed the following: 11/26/01 at 5:00 AM: "Yesterday pt was LOA after lunch. Pt. didn't come back at present time. Does not take 11/25/01 noc [night time] meds." 11/28/01 at 8:00 AM: "Pt did come back to facility. Insulin given..." The resident was AWOL approximately 68 hours and 30 minutes. 12/15/01 at 12:10 AM: "Pt up at nurse's desk, attempted to sign out in LOA book. Pt informed she could not sign out for LOA [at]this time. Pt again became belligerent, stating she was leaving facility. Pt informed she was not to leave facility + would be AWOL. Pt left the facility [at] this time.	F 280		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

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F 280	Continued From page 84 12/15/01 at 7:30 AM: "Pt returned from AWOL, had AM meds and Insulin. [No]apparent problems." 6. There was no documentation found in resident 5's medical record that the facility staff identified and assessed her continual AWOL behaviors, updated the Plan of Care to address the AWOL behaviors, or implemented interventions to stop the AWOL behaviors and protect the resident. RESIDENT 1 Resident 1 was a 42 year old male resident admitted to the facility on 8/7/01, with the following diagnoses: traumatic head injury, severe cognitive deficit with aggressive behaviors and aphasia (difficulty communicating). Resident 1 was admitted to the open area of the facility (not in the locked secure unit). Review of resident 1's medical record on 5/9/02, revealed the following: 1. A social service note dated 8/7/01, the day of admission, indicated the resident had a traumatic brain injury and severe cognitive deficit. "Resident is oriented to his name and with reminders can find his room." A note dated 8/16/01 documented that the "Resident is at risk for AWOL. He leaves the facility and wanting to go home." Notes dated 9/27/01 stated the following: "No progress shown with decreasing risk at AWOL. Resident has several episodes of successfully going AWOL from facility. A note dated 11/8/01 stated: "Resident has had several episodes of going AWOL from facility,	F 280		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

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F 280	Continued From page 85	F 280		

because he wants to go home. Resident does wear a ID bracelet and has always been brought back by police safely. Signs have been posted at front door to prevent him from leaving facility".

A social service progress note dated 4/18/02, stated: "Resident recently placed on NDU for structure environment due to going AWOL from facility numerous times. Poses himself to being a danger to self. Resident successfully made it to the airport and was brought back by police. Resident is unaware of his surrounding and whereabouts. Resident has always agreed to return to facility and does wear a ID bracelet. Resident is not adjusting well to being on NDU and has had an increase in behaviors and attempts to go AWOL when going to activities +/or [and or]meals....Resident will continue to reside on NDU for structure environment and for his safety."

2. Review of the nurses notes revealed ongoing incidents of AWOL from the date of admission 8/7/01 to 3/11/02, when the resident was placed in the NDU:

A note dated 3/11/02, documented the following: At 9:00 AM. "Pt. AWOL family and SLPD [Salt Lake Police Department] notified." At 5:00 PM "Pt returned to the facility - staff located pt. at SL airport - pt. placed in NDU - locked unit for more structured environment due to AWOL behavior - will cont. [continue] to monitor. Family notified."

A note written at 9:00 AM and dated 4/10/02, a month after the resident was transferred to the NDU, stated: "Pt. agitated - attempting to go AWOL from current events activity ..."

3. The care plan for resident 1 was reviewed. It included Problem #2 regarding an "alteration in behaviors", dated the day of admission (8/7/01). This

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

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F 280	Continued From page 86	F 280		

care plan problem was reviewed and continued without change by the IDT on these dates: 8/16/01, 9/27/01, 11/8/01, 1/31/02, 4/18/02 and 5/02/02. The care plan approaches included:

"(1). Document all AWOL attempts on data collection sheets on a 24 hr. basis.

(2). Monitor data collection sheets-report any changes to RN/DON.

(3) Monitor res. whereabouts frequently to decrease chances of AWOL.

(4). Provide reassurance/redirection as needed.

(5). If resident is successful in AWOL =
a. Search facility and grounds - announce on PA system.
b. Call police ASAP. [as soon as possible].
c. Notify RN/DON or owner/Adm.[administrator] also family &/or guardian.

(6). See policy on AWOL.

(7). Use validation techniques to discuss with the resident the emotions behind attempts to leave the facility.

(8). Assure res. is provided with ample physical activities.

(9). If tolerated place bell on wheel chair or shoe string so whereabouts can be readily determined".

Review of the care plan indicated that resident 1 was placed on a "Behavior Management Plan". It was dated 3/20/02, (nine days after the resident was placed in the NDU). The behaviors listed were aggression

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

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F 280	Continued From page 87	F 280		

with physical and verbal abuse. The behaviors were noted to revolve around cigarette issues or wanting to go home. The behaviors were directed toward staff, and there was a history of him directing his behaviors toward peers when they would not give him one of their cigarettes. The plan indicated that according to the data collection sheets there had been an increase in physical and verbal abusive behaviors and going AWOL from the facility related to wanting to go home &/or searching for cigarettes.

The care plan and the behavior management plan made no mention of resident 1 residing in the NDU which limited the residents ability to move freely about the facility and any additional behavioral manifestation this may have promoted. The only mention of the resident's environment was to "provide a calm, consistent, predictable environment".

The care plan was not updated when resident 1 was placed in the NDU

RESIDENT 3

Resident 3 was admitted to the facility on 2/1/02 with diagnoses that include schizophrenia, alcohol abuse, seizure disorder, closed head injury, neurologic deficit and post traumatic stress disorder.

Review of resident 3's closed record on 5/8/02 revealed the following:

1. A physician's order dated 2/1/02 documented that resident 3 could have LOA privileges with staff only.

2. Review of resident 3's plan of care, undated, documented under problem 3, that resident 3 was an "AWOL risk per previous history and cognitive impairment".

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

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F 280	Continued From page 88	F 280		

The approach for this care plan problem included "...3. Monitor residents whereabouts frequently to [decrease] chances of AWOL. ...5. If resident is successful in AWOL; A. Search the facility & grounds; B. Call police ASAP (as soon as possible) C. Notify RN/DON or Admin., also family and/or guardian".

3. A nurses note, dated 5/3/02 at 9:00 AM, documented "resident left facility around 9:00 AM didn't sign out didn't tell any one where he was going or when he would be back...will inform next shift about resident being AWOL".

A nurses note, dated 5/4/02 at 9:00 AM, documented "Search made of facility still unable to find Pt. (patient). [Police] notified...".

4. In an interview with the DON on 5/9/02 at 3:00 PM he stated that resident 3 always left the facility unattended and that he was quite capable at finding his way around. When the DON was questioned regarding resident 3's care plan and physician's order indicating that resident 3 was to be accompanied by staff when out of the facility the DON stated that the care plan and physician's order were in error.

5. The facility IDT did not reassess resident 3 and revise his plan of care to reflect his his ability to leave the facility unsupervised.

RESIDENT 4

Resident 4 was admitted to the facility on 1/29/02 with diagnoses that include dementia with depressive features and behaviors secondary to traumatic brain injury, hypertension, non-insulin dependant diabetes, prostate cancer, and colon cancer.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

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F 280	Continued From page 89 Review of resident 4's closed medical record on 5/9/02 revealed the following: 1. An admission physician's order, dated 1/29/02, documented resident 4 was to have LOA privileges with staff or family (but not independently). 2. The resident was admitted directly to the NDU on admission as an AWOL risk. 3. Review of resident 4's plan of care, undated, documented under problem 3, that identified resident 4 was an"AWOL risk per previous history and cognitive impairment". The approach for this care plan problem included "...3. Monitor residents whereabouts frequently to [decrease] chances of AWOL. ...5. If resident is successful in AWOL; A. Search the facility & grounds; B. Call police ASAP ; C. Notify RN/DON or Admin., also family and/or guardian 4. The nurses document, from 2/3/02 to 3/1/02 that the resident had no AWOL attempts, but that resident 4 would "wonder aimlessly" in and out of other residents rooms. A nurses note, dated 3/1/02 at 9:00 PM, stated "Pt. confused and came out frequently in new room (moved noon today). Couldn't sleep at night, observed anxious/nervous, reoriented about new surroundings. Will continue to monitor". A nurses noted, dated 3/2/02 at 12:15 PM documented "...no episodes of being AWOL since placed on open unit." No documentation could be found in resident 4's	F 280		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

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F 280	Continued From page 90 medical record that an assessment had been made by the IDT indicating why resident 4 was placed on the open unit. There was no physician's order found indicating to move resident 4 to the open unit and resident 4's care plan had not been updated to reflect any new changes. The nurses documented AWOL attempts by resident 4 on 3/2/02, 3/3/02, 3/8/02, 3/10/02. On 3/12/02 at 7:25 PM, a nurses note documented "CNA reported pt. is not in his room, search made of facility, unable to locate pt. in building. Unable to locate pt outside of bldg. [building] or surrounding area...Call placed to [police]...". At 8:45 PM the nurse documented that resident 4 was found in the NDU and the police were notified. A nurses note, dated 3/15/02 at 8:00 PM, documented "Pt. alert et [and] confused ongoing. Is resting in bed at New Directions Unit...". No documentation could be found in resident 4's medical record that an assessment had been done by the IDT indicating why resident 4 was placed back on the NDU. There was no physician's order found indicating to move resident 4 back to the NDU and resident 4's care plan had not been updated to reflect any new changes. 5. A review of resident 4's Care Plan Conference Summaries dated 2/2/02, 2/11/02, 2/28/02 and 3/28/02 all document that resident 4 was an "AWOL risk and continues to spend time on NDU". 6. The facility IDT did not reassess resident 4 when moving him to and from the NDU and did not revise resident 4's plan of care.	F 280		

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F 280	Continued From page 91 RESIDENT 7 Resident 7 was a 75 year old male admitted to the facility on 3/1/02 with diagnoses that included, dementia-Alzheimer's type with behaviors, Squamous cell carcinoma, diabetes mellitus, hypertension and anemia. On 5/14/02, review of the medical record for resident 7 revealed the following documentation: 1. A Social Service progress note dated 3/1/02 documented, "...Resident admitted to the NDU room ...[secondary to] wandering and at risk for endangering self. Resident is court committed....Resident is confused with periods of being oriented, able to discuss past at time...No insight into illness". 2. Review of the "Order for Commitment and/or Detention Pending Hearing and/or Examination" papers, dated 3/1/02, documented the following: "...Patient is demented, took off from a nursing home in Salt Lake City and was found in Provo 2 days later. Patient has no insight into his illness. He is Mentally ill and danger to himself." 3. Resident 7's hospital records, maintained in resident 7's facility file, dated 3/1/02 documented, " ...[resident 7] is a flight risk. He had gone AWOL time two. Last time yesterday after [cancer treatment center] appointment. ...has been a wanderer for years...continues to be elopement risk. He ran away from last ecf [extended care facility] and ended up in Provo..." 4. The nursing notes, dated 3/2/02, revealed the following documentation:	F 280		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

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F 280	Continued From page 92	F 280		

"0745 [7:45 AM] resident became very verbal [and] threatening toward staff attempted to give PRN's [as need medication] unable to give [at] this time resident took up to NDU accompanied by orderlies..."

"0755 [7:55 AM] NDU [residents and staff] came back upstairs [and] noticed that resident was not in the unit searched around the facility [and] up [and] down the block police notified [administrator] notified of resident taking off ss [social service] notified."

"1100 [11:00 AM] [hospital] called [and] stated that they had [resident 7] [and] that they would be bringing him back ..."

5. In an interview, on 5/14/02 at 1:00 PM, with the facility social service staff member, she stated that resident 7 was admitted to the facility due to his medical needs and wandering behavior. She stated that resident 7 attempted to go AWOL several times and in fact had gone AWOL one time. She stated that he was sent back to the hospital on 3/13/02 due to his increased behaviors and attempts to tear down the fence on the secure unit.

A nursing note, dated 3/5/02, documented, "NA [nurse aide] reported to unit that pt [resident 7] attempted to climb up and over fence of the alzheimer's locked unit [at] that time..."

A nursing note, dated 3/13/02, documented, " Pt. Attempting AWOL – trying to tear down the fence in the courtyard of the NDU – threatening physical harm to staff...MD notified [and] new order noted to transport pt ...to [name of hospital]..."

6. Review of resident 7's comprehensive plan of care revealed documentation that resident 7 was only allowed to leave the facility with staff or family

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

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F 280	Continued From page 93 members. There was no further plan of care addressing resident 7's wandering and AWOL behavior identified by the facility staff upon resident 7's admission to the facility. In an interview with the DON on 5/9/02, he stated that the IDT meets and reviews each resident quarterly. The DON stated the team documented the meeting on individual Care Plan Conference Summary forms. The DON also stated that the care plans are not reviewed and updated during the IDTmeetings. The facility did not develop or follow a systematic process to evaluate and care plan the placement of residents on the NDU or had AWOL behaviors.	F 280		
F 490 SS=K	483.75 ADMINISTRATION A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on an abbreviated survey with subsequent extended survey, conducted May 7, 2002 through May 10, 2002, and the resultant finding of Immediate Jeopardy to resident health and safety, the identified system failures in the facility in regard to the supervising, assessing and care planning of residents with AWOL (Absent Without Leave) behaviors; investigating and reporting incidents of AWOL to the required agencies; using the locked New Dimensions Unit (NDU) for control of behaviors and staff convenience; and lack of development and implementation of written policies and criteria for	F 490		

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HEALTH CARE FINANCING ADMINISTRATION

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F 490	Continued From page 94 investigating and addressing incidents of neglect, missing persons and AWOL incidents and appropriate use of the NDU; it was determined that the facility was not being administered in a manner that enabled it to use its resources either efficiently or effectively to ensure that residents were provided the opportunity to attain or maintain their highest practicable well-being and safety. This had the potential to effect all residents in the facility. Findings Include: On 5/7/02, an abbreviated survey was initiated. On 5/10/02, the facility administration was noticed of the elements of Immediate Jeopardy to resident health and safety and Sub-Standard Quality of Care. The determination of Immediate Jeopardy was based on findings of significant non-compliance in the areas of Abuse Prohibition [42 Code of Federal Regulations (CFR) 483.13(a)(c)1(i) and (2), Tags F-221, 224, F225, and F-226] and Administration/Quality Assessment and Assurance [42 CFR 483.75(o) Tag F-490 and 521]. Failure of the facility to address problems identified in these areas were present to such an extent that residents were residing in an environment in which the potential for resident harm was likely to occur. 1. Facility administration failed to have systems in place that would ensure that residents were provided with services to protect them from restraint via seclusion in the NDU (New Dimensions Unit) imposed for purposes of discipline or convenience, and not required to treat the resident's symptoms. (Refer to Tag F-221). 2. The facility did not assess, care plan and monitor residents with AWOL (absent without leave) behaviors	F 490	**F-490** **The Administrator will follow up on the above plan of correction to insure that it is accomplished as an ongoing part of the operation of the facility. The follow up will also include a review of the policy and procedures of the facility with new and current employee training. The employees will also be tested with spot checks that they not only were trained, but that they understand what their individual responsibility is in specific situations in regard to that training. The facility will be operated in a manner that does not tolerate nor allow resident neglect or abuse in any form.** **The Quality Assurance Committee will provide over-site of the administrator. The committee will be free of any penalty from the administration for discussing or pointing out deficiencies per the chain of command. The Administrator will not prohibit nor penalize any member of the committee from contacting the State if remedies for non complinance of any state regulations listed in this plan of correction or any other area covered by the Quality Assurance Committee are not pursued and achieved.**	6/8/02

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F 490	Continued From page 95 which lead to neglect. Neglect is defined as failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Residents who were cognitively impaired were allowed to leave the facility unsupervised exposing them to harm. (Refer to Tag F-224) 3. The facility failed to thoroughly investigate incidents of abuse or neglect regarding missing or AWOL residents, nor did they report the incidents or the results of their investigations to the State Survey Agency and to other officials in accordance with state law through established procedures. (Refer to Tag F-225) 4. The facility failed to develop and implement written policies and procedures that prohibited abuse or neglect from AWOL and restraint via seclusion in the NDU. (Refer to Tag F-226) 5. The facility's Quality and Assurance process failed to address incidents of residents AWOL behaviors, and to monitor and implement policies and criteria for the use of the locked NDU. (Refer to Tag F-521)	F 490	QA meetings will be held ~~Monthly~~ weekly x 1 mo. Then monthly x 3 then at least quarterly. Issues regarding these deficiencies will be discussed then.	
F 521 SS=K	483.75(o)(2)&(3) ADMINISTRATION The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.	F 521		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	C 5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR	125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 521	Continued From page 96 This REQUIREMENT is not met as evidenced by: Based on a review of the facilities Quality Assurance meeting minutes, facility monitoring systems, and interviews with the facility Administrator, and the Director of Nurses, it was determined that the facility's quality assessment and assurance activities did not develop and implement appropriate plans of action to correct identified quality deficiencies in the areas of residents' AWOL (absent without leave) behaviors, possible neglect of residents and the appropriate placement and maintenance of residents in the New Dimensions Unit (NDU). Findings include: 1. An interview was conducted with the facility Administrator on 5/13/02 at 1:00 PM, concerning the quality assurance process. He stated the department heads would bring their concerns to the quality assurance (QA) meetings. The meetings had been held quarterly however recently they had changed the frequency to monthly. Monitoring of issues was assigned to the department heads. The social service representative was also interviewed on 5/13/02, about the quality assurance process. She indicated they have met quarterly with the physician and pharmacist in attendance. They review concerns brought by staff, residents, and families. Identified problems were assigned to department managers who investigate and review findings in the next meeting. 2. On 5/13/02, the Administrator provided the survey team with minutes of four QA meetings dated: July 19, 2001, October 30, 2001, January 31, 2002, and April 16, 2002. The minutes of these meetings were reviewed by the survey team. There was no documentation found that the QA committee identified	F 521	**F-521** **The Quality Assurance Committee will meet and review the policy and procedures reflected in this plan of correction. The committee will meet at least quarterly for this purpose. An agenda will be made that specifically includes:** **Reporting and review of prior Quality Assurance Meeings. Including any follow up items that were recommened and accomplished.** **A report that the facility is following this plan of correction. This will include that documentation, review, training, and updates for each deficiency is followed as stated in the plan of correction.** **Suggestions for implovements and effectiveness of the overall operation of the facility.** **Notice to the committee of any residents that require or may require special Plans of Care, Assessments, and/or Behavior Management Plans.**	6/8/02

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F 521	Continued From page 97 and subsequently established corrective action plans to address the problem of AWOL behaviors, established and monitored criteria and procedures for the appropriate use of the NDU, and that processes were in place to identify and address situations of potential neglect by facility staff. 3. Quality deficiencies at the level of immediate jeopardy and substandard quality of care were identified during the abbreviated survey in the following areas: a. The facility did not ensure that residents placed in the NDU were free from physical restraints via seclusion imposed for the purposes of discipline or convenience, when not required to treat the resident's medical symptoms. (Refer to Tag F-221) b. The facility did not assess, care plan and monitor residents with AWOL behaviors which led to the neglect of residents. Neglect is defined as failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. (Refer to Tag F-224) c. The facility did not thoroughly investigate incidents of abuse or neglect to residents, missing or AWOL residents nor did they report the incidents or the results of their investigations to the State Survey Agency and to other officials in accordance with state law through established procedures. (Refer to Tag F-225) d. The facility failed to develop and implement written policies and procedures that prohibited neglect of residents by staff members and protected cognitively impaired residents from leaving the facility AWOL. (Refer to F-226)	F 521	**The meeting will include all personell that directly affect the implementation and follow through of this plan of correction along with any facility consultants that may influence and monitor compliance of state regulations and the facilities policy and procedures.** **The Administrator will be responsible that the Quality Assurance Committee meets at the required intervals and at a time when the members are available. The Administrator will also insure that the agenda is complete and reflects the issues stated above and that the addenda is followed and completed.** Administrator will participate in weekly IDT meeting every week x 1 month then monthly x 3 then at least quarterly.	6/8/02

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F 521	Continued From page 98	F 521		