Recid 6/10/02

NT OF HEALTH AND HUMAN SERVICES

Amendments to for per Telephone with Administrat Ob/12/02 1030 MPRINTED: 5/23/ FORM APPROVE 2567

HEALTH CARE FINANCING	ADMINISTRATION
	(X1) PROVIDER/SUPPLIER/CLIA

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

465124

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

5/10/02

NAME OF PROVIDER OR SUPPLIER

AND PLAN OF CORRECTION

MIDTOWN MANOR

STREET ADDRESS, CITY, STATE, ZIP CODE

125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

B. WING

COMPLAINT NUMBER. 6370, 6372

(X4) lD PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG

F 221

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

COMPLETE DATE

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

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 to meet the true requirement of least

completed and not just "rubber stamped" 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

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide difficient 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.

ATG117000

Event 1 J0Y111 Facility ID: UT0053

If continuation sheet 1 of

DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES (XJ) DATE SURVI Y (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 465124 5/10/02 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 125 SOUTH 900 WEST MIDTOWN MANOR SALT LAKE CITY, UT 84104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION 10 (X4) ID (EACH DEFICIENCY MUST BE PRECEEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DAT1 TAG DEFICIENCY) F 221 F 221 Continued From page 1 The policy states the NDU will not accept residents for to accomplish a more satisfying the purpose of: "1. Staff convenience 2. Involuntary environment for the resident. Another seclusion 3. Punitive punishment 4. Intermittent remedy is that, if it is found to be behavior management..." impossible to modify the perception of the residents desire to leave then a discharge **RESIDENT 2** plan will be put into place that will satisfy the resident, if possible, and the State so Resident 2 was admitted to the facility on 5/31/01, with diagnoses of paranoid schizophrenia, cognitive that the resident enters a situation that can disorder with behaviors, depression, suicidal ideations, best meet his/her needs. This system is in insulin dependant diabetes, and polysubstance and place and each team member is aware of alcohol abuse. their responsibility of on going review, both by the IDT and Quality Assurance. This has Resident 2's medical record was reviewed on 5/7/02. been implemented. 1. Review of the facility's contract agreement with resident 2, dated 6/13/01, indicated the following: Resident 1 has been assessed and his "I [resident 2], enter into this agreement with [the placement reviewed by the IDT team and facility]. I understand I will: independent consultant. (1), I will have my money's managed through [mental health caseworker]. 6/8/02 (2). Not use illegal drugs or alcohol. Resident 2 has been discharged from the (3). Agree to attend drug and alcohol groups through facility. [outpatient mental health]. (4). Agree to have urine and /or blood drug screen Resident 4 has been discharged form the tests done on a monthly basis and /or at the staffs facility. discretion. (5). Go to Social Services or RN [registered nurse]/DON [Director of Nursing] when I feel Other residents in the facility that are in depressed, sad, have pressure from other residents, or need of a more structured environment have need/desire to do illegal drugs or alcohol. such as these three residents will be Upon completion of the above I will be allowed to go assessed and monitored per the policy and into the community on a daily basis. If I do not procedures of the New Directions Unit. Any comply with the above, I will voluntarily place myself new admissions will receive the same on the locked unit for self protection." protocol if a more structured environment This form was signed by resident 2, the Social Service is suspected or indicated. representatives, and the Social worker on 6/13/01. ATG112900 Event 1 111701 Facility ID: UT'0053 If continuation sheet 2 of CMS-2567L

PRINTED 5:23 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVE HEALTH CARE FINANCING ADMINISTRATION STATEMENT OF DEFICIENCIES (XI) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING \mathbf{C} B. WING 465124 5/10/02 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 125 SOUTH 900 WEST MIDTOWN MANOR SALT LAKE CITY, UT 84104 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 221 Continued From page 2 F 221 The physician did not sign this form. There was no further documentation found in the resident's medical Even if placement on the NDU does occur, record to evidence the physician was involved in follow up of the placement will occur per developing the facility's contract agreement with the policy and procedure of the New resident 2. Directions Unit. Please see attached. 2. Review of the physician's orders from admission on 5/31/01 through 5/7/02 evidenced no documentation To ensure that we are in and remain in that the physician gave orders for the resident to be compliance the facility has hired an placed in the NDU. independent consultant to review our procedure of assessment and behavior 3. The mental health physician's notes, dated 1/24/02, management. This is per the directed plan stated "...On 12/26/01, [resident 2] was put on the closed/locked unit due to his repeated calls to 911. " of correction. The facility has already 6/8/02 received the initial consultation report and 4. The IDT (Interdisciplinary Team) meeting minutes the first weekly report. A copy of these are were reviewed for the dates of 5/31/01 through 4/2/02 attached indicating our progress and No documentation was found to evidence the resident's compliance with the directed plan. attending physician was an active member of the IDT The IDT team has been inserviced to ensure Documentation of the IDT meeting for the date that the system is in place is to make good 2/21/02 indicated the following: judgement regarding the finding of resident assessments and effective "... Plan of Care: Nursing... Placed on NDU followup of useful behavior management [secondary to] phone calls made to emerg. plans. This inservice was held on June 4th [emergency] services...Summary of Care Plan and given by the independent consultant. Conference Discussion. Pt moved out of NDU in Feb. [February] [with] I episode noted of inapp. [inappropriate] phone use. Will monitor for cont. [continued] episodes. Pt informed if episodes cont. This plan of correction was reviewed by the [continue] he will be placed on NDU again." There Quality Assurance Committee on June 4, was no documentation found in the IDT meetings 2002. This plan will be monitored by the regarding the specific dates of when resident 2 was

CMS-2567L

NDU.

ATG112000

placed in the NDU or when he was released from the

5. The nurse's notes were reviewed from 5/31/01 through 4/2/02. Documentation included the

Event ! 10Y111

Facility ID: UT0053

If continuation sheet 3 of

Utah Dept. of Health

JUN 0 6 2002

DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

C

5/10/02

465124

B. WING

STREET ADDRESS, CITY, STATE, ZIP CODE

MIDTOWN MANOR

125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

F 221

(X4) ID PREFIX TAG

CMS-2567L

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

1D PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

COMPLETE

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.

OA 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/10T will meet weekly for one month then eyery month.

ATG112000

10Y111

Facility ID: UT0053 If continuation sheet 4 of

HEALI	II CARE I II ANCINC	ADMINISTRATION		_,			2567
	T OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER IDENTIFICATION NUM 465124		(X2) MULTIP A. BUILDING R. WING	LE CONSTRUCTION	(X3) DATE COMPL	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		710/02
	VN MANOR		125 SOUTI	H 900 WEST E CITY, UT			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIE: Y MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL :	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (ROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
	following him all over [with] a knife - pt. discrete the placed environment/supervise. 6. Review of resident evidenced the follow "Problem #1: Altera worsening of chronic [resident] is not to lest [without] staff or [with	"Police came to desk a d said that [another reser the facility and thread not notify any of the ed by any witnesses, stain NDU for more struction." It 2's Plan of Care, date ing: It in in behavior r/t [relation in behavior resident of the facility unsupervise thout] approval from II The representative was in the resident of the facility of the resident of the NDU in the facility did not be the resident of the NDU. The facility did not cause the resident of the NDU. Summentation found to ended the resident's physical said and the resident's physical said and the resident's physical said the residen	sident] was tening him staff. aff or tured d 6/13/01, ated to] 7. Res. ed DT." atterviewed cility had a ents for then asked ace to assess I, the DON place. systematic ment of assess or using the re to reflect vidence vsician in	F 221			
	the decision to place	the resident on the ND	U.				•

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (XI) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C B. WING 465124 5/10/02 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 125 SOUTH 900 WEST MIDTOWN MANOR SALT LAKE CITY, UT 84104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) F 221 F 221 | Continued From page 5 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

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MULTIPL A. BUILDING B. WING	LE CONSTRUCTION	(X3) DATE S COMPLI	eted C
		465124	PART 15 -				10/02
NAME OF P	ROVIDER OR SUPPLIER			RESS, CITY, STA	TE, ZIP CODE		
MIDTOV	VN MANOR			H 900 WEST Œ CITY, UT	84104		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY .SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
F 221	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						
	1	se order for leave of ab ay] go out on pass with ions".	i				
	3. Social Service Profollowing:	ogress notes documente	d the	:			
	admission, indicated injury and severe cog	dated 8/7/01, the day of the resident had a traur entitive deficit. "Resident and with reminders can	natic brain nt is				
		documented that the "I de leaves the facility and		•			:
	progress shown with Resident has several AWOL from facility incident and police h facility unharmed. W	stated the following: "Necreasing risk at AW(episodes of successfull: Police were notified cave brought resident bavife has purchased ID battonResident short."	OL. y going of every ck to ractlet				
	several episodes of g because he wants to g ID bracelet and has a police safely. Signs prevent him from lea	stated: "Resident has a oing AWOL from facility of home. Resident does always been brought back have been posted at froz ving facility".	ity, s wear a ek by nt door to				

CMS-2567L

	OF DEFICIENCIES DEFICIENCIES	(XI) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION	(X3) DATE COMPL	ETED C
	COURSED ON CUINDLES	465124	STREET ADDI	DESCRITY STAT	T ZID CODE	5	/10/02
	ROVIDER OR SUPPLIER VN MANOR		125 SOUTI	RESS, CITY, STAT 1 900 WEST E CITY, UT 8			
(X4) ID PREFLX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE: CY MUST BE PRECEEDED BY R LSC IDENTIFYING INFORMA	FULL	ID : PREFIX ! TAG ;	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	COMPLETE DATE
F 221	reference to the sig posted on the front 1 when leaving the for a while but late sign was observed residents to stop ar	or of nurses, where he mans. He indicated that signor of the facility to ston facility. He stated it works seemed to have no effect by the surveyor and it did be sure to check out prowas not specifically direct.	ns were op resident rked well ct. The rected ior to	F 221			
	"Resident recently environment due to numerous times. F self. Resident successed was brought back this surrounding an agreed to return to bracelet. Resident NDU and has had attempts to go AW [and or]mealsRe	progress note dated 4/18/placed on NDU for struct placed on NDU for struct places himself to being a disessfully made it to the air place. Resident is und whereabouts. Resident facility and does wear a list not adjusting well to be an increase in behaviors a OL when going to activity esident will continue to reenvironment and for his servironment and for his servironment.	ture lity anger to rport and aware of has always ID eeing on and ties +/or eside on				
	when resident 1 was involved in the dec involved or the ass	progress notes did not do as placed in the unit, who dision making, if the phys essment process that was after placement. The note ase in behaviors.	was ician was used to				
	5/9/02, indicated to notified and agreed When questioned a place residents in to (interdisciplinary to administrator. She	the Social Service represent the resident's guardiant to the placement in the subout who made the decision he unit she stated usually eam) would discuss it also stated resident 1 was plat AWOL and was found a	was secure unit. sion to the IDT ong with the seced in the				

DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MULTIPI A. BUILDING B. WING	LE CONSTRUCTION	(X3) DATE COMPI	
		465124		B. WING		5	/10/02
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
MIDTOV	VN MANOR			H 900 WEST KE CITY, UT	84104		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIE / MUST BE PRECEEDED BY .SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(XS) COMPLETE DATE
F 221	Continued From page 8 airport.	3		F 221			
		vsicians orders revealed in resident 1's medical he NDU.					!
	revealed the following documenting IDT me	re Plan Conference Sur ng (The summaries are cetings which are held nt care issues and care p	brief notes at least				
	1/31/02, documented	nry for the second quar I the following: "decre erbal, cursing down, A	asing	:			
	4/18/02, documented to have an increase in the unit: "Pt. placed episodesPt. will A activities must be in	ary for the third quarter I that the resident had be not behaviors after he was on NDU due to ongoin WOL with outside ND NDUPhysical, verband with physical outburst."	peen noted as placed in ag AWOL U activity - I outbursts;				
	dated 5/2/02, docum deficit due to TB1 [to the NDU. Behaviors increasedAttended did leave activity in NDU] Increased b [continued] attempte episodes physically	nmary for an MDS statented the following: "Naumatic brain injury] ps-physically abusive d bingo out of NDU anthe day room [also out behaviors-hitting, verbard AWOLsongoing cattacking staff. Long to owards staff since being	Memory blaced on d stayed - of the il-cont. combative erm care.				
	In the portion of the	form titled "Summary	of Care				

STATEMENT OF DEFICIE AND PLAN OF CORRECT		(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM	/CLIA IBER;	A. BUILDING	CONSTRUCTION		SURVEY LETED
		465124	-	B. WING			
NAME OF PROVIDER OR	SUPPLIER		STREET ADDR	ESS, CITY, STAT	E. ZIP CODE	<u>_</u>	5/10/02
			125 SOUTH		-,		
MIDTOWN MANO			SALT LAK	E CITY, UT 8	4104		
		ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY		ID	PROVIDER'S PLAN OF O	CORRECTION	(X5)
PREFIX (EAC) TAG REGU	LATORY OR L	SC IDENTIFYING INFORMA	IION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLETE DATE
F 221 : Continued Plan Con		ussion" it stated: "Pt.]	ns had	F 221			
		attempted AWOLs - p		•			
physically	aggressive	with redirection back	n NDII"	i			!
		ied an increase in beha		:			
		which was held eight w		•			
		in the NDU.	cks affer	į			
. 100,000	do praceo	m the PADO.		:			:
10 Revie	w of the nu	rses notes revealed ong	oina .	;			
incidents	of AWOL f	om the date of admiss	on 8/7/01				
		esident was placed in					
9:00 AM. Police De	"Pt. AWOI partment] n	documented the follow family and SLPD [Sa otified." At 5:00 PM " /- staff located pt. at S	lt Lake Pt				
nt placed	in NDH - k	ocked unit for more stri	L airport -				
environm	ent due to A	WOL behavior - will c	ont	1			
		Family notified." Th					
		t the decision making p					
		sident 1 in the secured					
		ntation of who was inv					
the decisi	on i.e. staff i	nembers, physician.	here was				
no indicat	ion in the no	ote about whether the fa	mile				
		simply of the AWOL, of					
guardian y	vas actively	involved in making the	decision	:			
		the NDU.	decision				
10 p.200 ti				:			
A note da	ted 3/19/02.	eight days after it appe	ars the	!			
resident w	as transferre	ed into the NDU, document	mented	!			
		een by the physician fo		·			
		New medication orde		•			
		ease the agitation and		1			
	ent plan was		· ocharior	İ			·
A note wr	itten on 4/24	02, six weeks after ad	mission				!
		that resident 1 "contin					
		nificant changes noted					
The reside	ent had displ	ayed an increase of bel	naviors,				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH	I CARE FINANCING	<u>ADMINISTRATION</u>					2567
	OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER SUPPLIER IDENTIFICATION NUM		(X2) MULTIP A. BUILDING B. WING	LE CONSTRUCTION	(X3) DATE COMPL	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY. STA	TE, ZIP CODE		
	VN MANOR			H 900 WEST KE CITY, UT	84104		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
F 221	after he was placed of included Problem #2 behaviors", dated the care plan problem without change by the 9/27/01, 11/8/01 1/3 change in the care plan problem without change by the 9/27/01, 11/8/01 1/3 change in the care plan problem without change in the care plan placed in the Niticulaed: "(1). Document all Asheets on a 24 hr. ba (2). Monitor data cotto RN/DON. (3) Monitor res. which chances of AWOL. (4). Provide reassure (5). If resident is sure a. Search facility and system. b. Call police ASAFte. Notify RN/DON family &/or guardia (6). See policy on A (7). Use validation resident the emotion facility. (8). Assure res. is placetivities. (9). If tolerated placetic pla	equested additional medon the NDU. or resident 1 was review 2 regarding an "alteratione day of admission (8/7) as reviewed and continue IDT on these dates: 8 1/02, 4/18/02 and 5/02/1 lan was made when the DU. The care plan appropriate the care plan appropriate to discuss which are plan appropriate to the care plan appropriate to the care plan appropriate to the care plan appropriate to the plan ap	dications red. It on in 7/01). This ued 8/16/01, /02. No resident roaches decrease ded n PA strator) also ith the ive the sical r shoe	F 221	DETICIENCY		
	There was no indica	its can be readily determation in the medical records: to: place a bell on the reack of the resident, was dent 1 in the unit.	ord that the				

DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM 465124		(X2) MULT A. BUILDE B. WING	•	_	LETED C
NAME OF PR	OVIDER OR SUPPLIER	1 402124	STREET ADD	RESS, CITY, S	TATE, ZIP CODE		5/10/02
				H 900 WES			
MIDTOW	'N MANOR		SALT LAN				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	(EACH CORRECTIVE	OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE ENCY)	(X5) COMPLETE DATE
F 221	Continued From page 1	11		F 221			į
	12. Review indicated "Behavior Managem (nine days after the runit). The behaviors physical and verbal at to revolve around cighome. The behavior there was a history of toward peers when the their cigarettes. The the data collection shiphysical and verbal a AWOL from the facility of the care plan and the no mention of reside which limited the resident and the facility and any at this may have promo	d that resident 1 was plent Plan". It was dated esident was placed in the listed were aggression abuse. The behaviors we garette issues or wantings were directed toward fair him directing his behavior would not give him plan indicated that accepts there had been an abusive behaviors and gility related to wanting igarettes. The behavior is not directed towards behavior. The behavior management of the second of the seco	yere noted g to go staff, and aviors one of ording to increase in coing to go home altering	* 221			
	restrictive alternative placing resident 4 in documentation that t decision making prodocument clearly that for the move to the use systematic process.	nentation indicating whoses were tried or consider the NDU. There was not he physician was involucess. The nurse's notes at the guardian had give unit. It was not clear the or criteria used in deciment by placement in the	red prior to o ved in the did not on consent at there was ding				
	RESIDENT 4			•			
			: :				
CMS-25671.		ATG112000 Event K	0Y111	Facility ID:	UT0053	lf conti	nuation sheet 12 of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMB			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED C		
		465124				5	/10/02
	ROVIDER OR SUPPLIER VN MANOR		125 SOUT	PRESS. CITY, STA H 900 WEST KE CITY, UT	ST		
(X4) ID PREFLX TAG			FULL	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETE DATE
F 221 Continued From page 12 Resident 4 was admitted to the facility on 1/29/02 diagnoses that included: dementia with depressive features and behaviors secondary to traumatic brainjury, hypertension, non-insulin dependant diabet prostate cancer, and colon cancer. Review of resident 4's closed medical record on 5/9/02, revealed the following:		essive ic brain diabetes,	F 221		,		
	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).		A (leave of				
	indicated that residen long term memory, n skills (decision makin required). Indicators	nission MDS, dated 2/1 it 4 had problems with noderately impaired con ng poor, cues/supervisi of delirium and disord ented as "easily distrac	short and gnitive on ered				
	He was targeted as having difficulty with communication: "sometimes understood (ability is limited to making concrete requests)", and "Sometime understands (responds adequately to simple, direct communication)".		Sometimes	:			
		lering behaviors that of He was also documen th 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".						
	Monitor residents wh	care plan problem inc ereabouts frequently to f AWOL 5. If reside	•				:

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 5/10/02 465124 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 125 SOUTH 900 WEST MIDTOWN MANOR SALT LAKE CITY, UT 84104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEEDED BY FULL COMPLETE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) F 221 Continued From page 13 F 221 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C B. WING 5/10/02 465124 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 125 SOUTH 900 WEST MIDTOWN MANOR SALT LAKE CITY, UT 84104 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEEDED BY FULL COMPLETE PREF1X PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) F 221 Continued From page 14 F 221 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. 483.13(c)(1)(i) STAFF TREATMENT OF F 224 F 224 RESIDENTS SS=K 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.)

		AND HUMAN SERV ADMINISTRATION					ED: 5/23/ APPROVE 2567
STATEMENT	OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER IDENTIFICATION NUM	VCLIA	(X2) MULT A. BUILDIN B. WING	ILE CONSTRUCTION	3) DATE SUR COMPLETE C	:D
		465124				<u>5/1</u> 0	/02
NAME OF PE	ROVIDER OR SUPPLIER		STREET ADD	RESS. CITY, S	TATE, ZIP CODE		
MIDTON	VN MANOR			H 900 WEST KE CITY, U			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEEDED BY LSC IDENTIFYING INFORMA	FULL.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(XS) COMPLETE DATE
F 224	Continued From page This REQUIREMEN	15 NT is not met as eviden	nced by:	F 224	:	1	
	facility policies, and that the facility did r residents with AWO which led to neglect Neglect is defined a services necessary to	resident medical record staff interviews it was not assess, care plan and L (absent without leave for 5 of 8 sample resids failure to provide good avoid physical harm, llness. Residents 1, 2, 2	determined of d monitor e) behaviors i lents, ids and mental		Resident 1 has been assessed for appropriate placement on the NDU the proper procedure having been for and reviewed by the independent consultant. The NDU policy and prowill be followed for continued review	ollowed	
	Findings include:	d to optablish and insul	>=====		Resident 2 has been discharged.		
	policies which ident	d to establish and implo ified situations which c ilure to identify the aba	constitute		Resident 3 has been discharged.		
	of residents by a cha missing residents, it	arge nurse, AWOL resi avoluntary seclusion of	dents residents		Resident 4 has been discharged.		6/8/02
		which resulted in resid rvices that the facility vide.			Resident 5, who is not on the NDU been evaluated and received new L requirements that are less restrictive	.OA	
	2. The facility addi	tionally failed to imple	ment the		was reviewed by Valley Mental Heal		

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

when residents were determined to be missing.

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:

already established policy regarding steps to be taken

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

QA Committee and the residents doctor.

Resident 7 has been discharged.

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

5/10/02

DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

(X1) PROVIDER/SUPPLIER CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

465124

B. WING STREET ADDRESS, CITY, STATE, ZIP CODE

125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

MIDTOWN MANOR

SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG

PREFIX TAG

F 224

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

the location of residents are monitored

and, that if missing or AWOL, a procedure

(X5) COMPLETE DATE

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

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

6/8/02

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

ATG112000

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING \mathbf{C} B. WING 5/10/02 465124 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 125 SOUTH 900 WEST MIDTOWN MANOR SALT LAKE CITY, UT 84104 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5)(X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX PREFLX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 224 F 224 | Continued From page 17 and police notified 7 hours after AWOL included. A procedure has been 3. 4/1/02 5:30 AM to 4/2/02 5:00 PM. Police notified implemented so that agencies who by facility 4/2/02 1:00 PM. Police notified 31 1/2 received a report of a missing resident are hours after AWOL discovered and resident was found contacted about the residents return and 35 1/2 hours after noted missing. any pertinent data regarding the resident, such as physical condition, etc. This Resident 2's medical record was reviewed on 5/7/02 procedure was completed and 6/8/02 and documented the following: implemented along with the inservice 1. Review of the physician's orders revealed an order, training. The information is attached. dated 5/31/01 (the resident's admission date to the A specific agenda item will be included for facility), stating the resident "May go out on pass with discussion at the Quality Assurance family, staff with medications." This indicated the Meetings. The effectiveness of these resident was not to leave the facility unsupervised. procedures will be reviewed, monitored, and revised if improvements are indicated 2. Review of the resident 2's Social Service Progress Record, dated 5/31/01 indicated, "...Long term or recommended. memory is fair and short term memory is poor...He lacks judgement and has little insite into his medical or Inservices on the above procedures were. psychiatric condition..." given on May 11th; May 13th; May 14th; May 15th: & May 30th. All shifts, and all 3. Review of resident 2's Plan of Care, dated 6/13/01, personnel received this inservice. evidenced the following: The inservice was given by the Problem #1: "Alteration in behavior r/t [related to] Administrator and Social Services. Follow worsening of chronic illness....May be complicated by up training will be done for review of 1. Behavior that endangers resident...External factors: current employees, and orientation for new 1. Poor decision making ability..." employees. The schedule for ongoing Approach: "...7. Res. [resident] is not to leave review of the policy and procedure is a facility unsupervised [without] staff or [without] mandatory employee meeting on the third approval from IDT (Interdisciplinary Team)." Friday of each month. 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

CMS-2567L

Event 1 10Y111

PRINTED: 5/23/ FORM APPROVE

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MULTIP		UCTION	(X3) DATE SU COMPLET	ED
		465124		B. WING			5/1	0/02
NAME OF PE	ROVIDER OR SUPPLIER	103121	STREET ADDR	ESS, CITY, STA	ATE, ZIP COI	DE.	1	0,02
				1 900 WEST				
MIDTOW	VN MANOR		SALT LAK	E CITY, UT	84104			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIE. MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF CORREC' CH CORRECTIVE ACTION SHO SS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
F 224	Continued From page basis. B. Have [no] thoughts/plans on a capproach: "7. Assevaluate the level of Documentation on reit had been reviewed The was no evidence these problems had be facility staff on the description of the description of the description of the facility staff on the description of the facility staff on the description of the facility suicide and accompanied by a store of the facility suicide in the past be out in the communital leave facility unsupper from IDT. 11. Assevention of the facility unsupper from IDT. 11. Assevention of 5/31/01 through the following: 1/6/02 at 6:00 PM: 18:40 [6:40 PM] ar no documentation for attempted to locate	verbalizations of suicidally basis." sess Res. suicidal potent suicide precautions dailers lesident 2's Plan of Carellon 7/26/01, 9/6/01, and found that the Plan of poen updated or change lates reviewed. Avior Management Planed and it documented to the sesidents whereabouts whereabouts whereabouts while at actions/attempts. Sever physical harm on a daile Residents whereabouts which was member while at action of the sesident suicidal probability. Res. will not be allowers resident's suicidal probability suicide precautions days were reviewed for the 4/2/02. Documentation of the disappeared" "Pt refused [medication of the disappeared" ound to evidence the for resident 2 or notified to the resident 2 or notified to the suicident 2 or notified 2 or notifie	evidenced d 11/24/01. Care for d by the dated he	DON/10- then	Nursing Quarter Howeve plan wa Commit insure t into effe	be monitored by the Dir and part of his report at ly Quality Assurance Me r, the initial implementa s reviewed at a Quality A ttee Meeting on June 4, hat viable plan had bee	the etings. etion of the Assurance 2002 to n placed	6/8/02
	when the resident d into the facility, he numberbecause h	isappeared. "Police stated [resident 2] got e tried to do a suicide i atient was taken to the	officer came a crime n the middle	:				
CMS. 2567		ATG112000 Event l	10Y111	Facility ID:	UT0053	·	If continu	ation sheet 19 of

Facility ID: UT0053

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 5/10/02 465124 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 125 SOUTH 900 WEST SALT LAKE CITY, UT 84104 MIDTOWN MANOR PROVIDER'S PLAN OF CORRECTION (X5)SUMMARY STATEMENT OF DEFICIENCIES 1D (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG F 224 Continued From page 19 F 224 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."

PRINTED: 5/23/ FORM APPROVE DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 5/10/02 465124 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 125 SOUTH 900 WEST SALT LAKE CITY, UT 84104 MIDTOWN MANOR PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE DATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG F 224 F 224 : Continued From page 20 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

Event 1

DEPARTMENT OF HEALTH AND HUMAN SERVICES <u>IEALTH CARE FINANCING ADMINISTRATION</u>

FATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER:**

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

C 5/10/02

465124

STREET ADDRESS, CITY, STATE, ZIP CODE

B. WING

125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

MIDTOWN MANOR

(X4) ID

PREFIX

TAG

IAME OF PROVIDER OR SUPPLIER

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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 21

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....l 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,

F 224

Event l

5/10/02

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING_ 465124 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 125 SOUTH 900 WEST

(X3) DATE SURVEY COMPLETED \mathbf{C}

WOTOW	N MANOR	SALT LAP	(E CITY, UT	84104	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY F REGULATORY OR LSC IDENTIFYING INFORMAT	TULL TON)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETE DATE
F 224	Continued From page 22 and the food line.		F 224		
	and the 100d time.				!
	At 1751 [5:51 PM] the workers from the foo	d line			
	called and said [resident 2] was there. Office	er [name			
	of officer] went to the line and confirmed it	was indeed			
	[resident 2].		:		
		the Maner			1
	In the past 6 months we have been called to	me manor			1
	7 times for walkaways/missing persons."				
	7. The DON (Director of Nurses) was inter-	viewed 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 residence	dent is not			
	found within 30 minute, the nurse then notif	fies the			
	police, the resident's physician and family o	r guardian.			i
	The DON also stated the nurse should fill o	ut an			:
	incident report and document the incident in resident's chart in detail. When asked for the	n inc se incident	ŧ		
	reports for resident 2's AWOL events for 1/	/6/02			k
	3/6/02 and 4/1/02, the DON was unable to	locate the			
	documentation.				•
	documentation.				i
	8. The facility failed to follow their missin	g patient	•		
ı	policy by not attempting to locate resident?	2 or notify			1
i	the police in a timely manner after determine	ning that he	!		
	was missing. There was no documentation	found that			
	the resident 2's physician was notified cons	sistently			
	when the resident was missing. There was	no inni recersi			
	documentation found in the resident's medi	icai record	·0		F.
	to evidence the IDT team gave the resident	i appiovai i	v		
	leave the facility unattended. There was no documentation in resident 2's medical reco	ord that the			
	facility staff identified and assessed his or	ngoing			: '
1	AWOL behaviors, updated the Plan of Car	re to addres	S		:
	the AWOL behaviors, or implemented inte	erventions t	.0		
	stop the AWOL behaviors and protect the	resident.			
	Stop the A to OD ochariois and protect me				

DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 5/10/02 465124 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **125 SOUTH 900 WEST** MIDTOWN MANOR SALT LAKE CITY, UT 84104 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES m (X5) (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEEDED BY FULL COMPLETE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 224 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 li continuation sheet 24 of ATG112000 Facility ID: UT0053 Event I 103/1111 CMS-2567L

FORM APPROVE EPARTMENT OF HEALTH AND HUMAN SERVICES <u>IEALTH CARE FINANCING ADMINISTRATION</u> (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: ND PLAN OF CORRECTION A. BUILDING B. WING 5/10/02 465124 STREET ADDRESS, CITY, STATE, ZIP CODE AME OF PROVIDER OR SUPPLIER 125 SOUTH 900 WEST SALT LAKE CITY, UT 84104 JIDTOWN MANOR PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES 10 (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) TAG 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:

PRINTED: 5/23/

EPART!	MENT OF HEALTH	AND HUMAN SERV	ICES			FOR	M APPROVE 2567
HEALTH CARE FINANCING ADMINISTRATION TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (XI) PROVIDER/SUPPLIES IDENTIFICATION NU		VCLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPL	(X3) DATE SURVEY COMPLETED C	
		465124		B. WING		5	/10/02
AME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STAT	E, ZIP CODE		
	'N MANOR		125 SOUTH SALT LAKE	900 WEST E CITY, UT 8	34104		
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIE CY MUST BE PRECEEDED BY LSC IDENTIFYING INFORMA	FULL '	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
	Continued From page 1/10/02: "Care Pla Ongoing AWOL'S. Conference Discus AWOL ongoing" 3/28/02: "Care Pla Ongoing AWOL 6. The nurse's note revealed the follow 11/26/01 at 5:00 A lunch. Pt. didn't countries was document resident was AWO found regarding the resident or that the determined the resident or that the determined the resident was resident	e 25 n ElementRisks/conseSummary of Care Plarsion: Multi [multiple] ed In ElementRisks/conse es for resident 5 were reving: M: "Yesterday pt was some back at present time [night time] meds." No need for when the staff need at the police were notified we sident was AWOL. PM: "Pt is AWOL now AM: "Pt remains AWO AM: "Called and report approximately 44 hours	equences: pisodes of equences: viewed and LOA after e. Does not o specific oted the mentation cate the hen the staff v" L." ted missing to s after the k to facility. L	F 224	DEFICIENCY		
	Pt informed she time. Pt again b	O AM: "Pt up at nurse's nout in LOA [leave of a could not sign out for Leecame belligerent, statin Pt informed she was no be AWOL. Pt left the f	bsence] book. OA [at] this ig she was t to leave				

time.

DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIER

(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

5/10/02

465124

STREET ADDRESS, CITY, STATE, ZIP CODE

B. WING

	/N MANOR S	25 SOUTH 900 WEST ALT LAKE CITY, UT	TH 900 WEST KE CITY, UT 84104			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATIC	ID IL PREFIX ON) 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 facility [at] this time."	F 224				
	12/15/01 at 12:35 AM: "Call placed to SLPD Lake Police Department] to report pt AWOL. Awaiting call back from SLPD for report to be case [number]."	: 1				
	12/15/01 at 2:00 AM: "Pt not back to facility awaiting call back from SLPD."	, still				
	12/15/01 at 7:30 AM: "Pt returned from AW AM meds and Insulin. [No] apparent problem	OL, had				
	7. Review of a police report on 5/13/02 docu the following incident:	mented				
	The report which was dated 11/27/01, docume the incident regarding resident 5 occurred on at 11:30 AM, and was reported by the facility police two days later, on 11/27/01 at 8:47 Al report further documented, "Comp. [complai reports the walk away [resident 5] was last Sunday 11/25/2001 at about 1130 [11:30 AN not been seen or heard from her since She walked away a number of times before but all come back the next day, they have no idea we may be this time."	11/25/01 y to the M. The nant] t seen 4]. Has had				
	8. The facility failed to follow their missing policy by not attempting to locate resident 5 the police in a timely manner after determinishe was missing. There was no documentation resident 5's medical record that the facility soldentified and assessed her continual AWOL behaviors, updated the Plan of Care to address AWOL behaviors, or implemented intervention the AWOL behaviors and protect the resident stop the stop the stop the stop the AWOL behaviors and protect the resident stop the	or notify ing that ion in taff ess the tions to				

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVE HEALTH CARE FINANCING ADMINISTRATION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION TATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: ND PLAN OF CORRECTION A. BUILDING B. WING 5/10/02 465124 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 125 SOUTH 900 WEST SALT LAKE CITY, UT 84104 MIDTOWN MANOR PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG F 224 F 224 : Continued From page 27 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

Event 1

EPARTN	MENT OF HEALTH CARE FINANCING	AND HUMAN SERVI ADMINISTRATION	CES				2567
ATEMENT OF DEFICIENCIES (XI) PROVIDER/SUPPLIER IDENTIFICATION NUMBER OF CORRECTION (XI) PROVIDER (XI) PROV		CLIA BER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE S COMPLE	TED C	
		465124		B. WING		5/	10/02
ME OF PR	OVIDER OR SUPPLIER			ESS, CITY, STATE	E, ZIP CODE		
	'N MANOR		125 SOUTH SALT LAKE	900 WEST E CITY, UT 8-	4 104		
(X4) ID PREFIN TAG .	SUMMARY ST	TATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETE DATE
	do?". He also had occurred on 1 to 3 c	ns-e.g., Where do I go? verbally abusive behaviorally days in a week.	What do l or which	F 224			
	Resident 1 was also with walking. The resident had a legal	documented as being in assessment indicated that guardian.	nt the				
	indicated that he had nursing facility. A under Problem #2: worsening of chromas implemented v 8/7/01.	are plan for resident 1 or and a history of AWOL in WOL behaviors were ad "Alteration in behaviors ic illness." The date the was listed as the day of a	a previous planessed some care planessed admission		÷		
	continued without	e plan problem #2 was rechange by the interdiscinented as: 8/16/01, 9/27/and 5/02/02.	plinary team			·	; ;
	of breaking down the last nursing fa- would state 'call n Complications we "1. Behavior that 2. Diff. [difficulty	nifested by resident 1 we door and attempts to go cility the resident lived in dad, 1 want to go homere listed as: endangers the res. [reside] in dealing with people	AWOL at n. Resident ne".				
	associated with n factors were note	f the behavior was "prbs eurological disease". E d to be Psychotropic me d poor decision making a njury and severe chronic	eternal ds. ability due to				
	Caro alon approa	aches for problem #2 we	re listed as:				-

PRINTED: 5/23/

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVE HEALTH CARE FINANCING ADMINISTRATION (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (XI) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 5/10/02 465124 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 125 SOUTH 900 WEST MIDTOWN MANOR SALT LAKE CITY, UT 84104 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE DATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 224 F 224 : Continued From page 29 "(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 (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 (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.

documented the following:

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

Event I

DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C B. WING 5/10/02 465124 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 125 SOUTH 900 WEST MIDTOWN MANOR SALT LAKE CITY, UT 84104 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 224 F 224 | Continued From page 30 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] Event I

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 5/10/02 465124 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 125 SOUTH 900 WEST MIDTOWN MANOR SALT LAKE CITY, UT 84104 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5)(X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFUX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 224 Continued From page 31 F 224! 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING C B. WING 5/10/02 465124 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 125 SOUTH 900 WEST MIDTOWN MANOR SALT LAKE CITY, UT 84104 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 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 I 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", If continuation sheet 33 of ATG112000 Facility ID: Event I 10Y111 CMC-2567L

EALTH CARE FINANCING ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION		(XI) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NUMBER: 465124	A. BUILDING B. WING		C 5/10/02	
VE OF PR	OVIDER OR SUPPLIER	STREET ADDI	RESS, CITY, STATE,	ZIP CODE		
	N MANOR	125 SOUTI SALT LAK	l 900 WEST E CITY, UT 841	104		
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIN TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BÉ	(XS) COMPLETE DATE
5 224	Continued From page	32	F 224			
1 224	che stated from betw	een 1 to 3 hours. She stated that				1
	she did not know ho	w resident 1 got to and from the seen any facility staff come and		•		
	store, but nad never	arn him to the facility.	1			
						į
	10. Police reports v survey team on 5/13	were obtained and reviewed by the 3/02:				. :
	following: "The cor 1]left sometime as not been seen since damageand cannot [Resident 1] has be address of local gro today. I also check station], but he has know [resident 1], band with his name [number] on it.	d 3/11/02 and documented the implainant reported that [resident round 0700 hrs [7:00 AM], and has [Resident 1] has severe brain of find his way back if he goes out en known to go to the [name and ocery store] but they haven't called ted [name and address of local gas in't been there today. They also [Resident 1 has a permanent wrist e and the [facility's] phone #				
	[in the past], trying [Resident 1's] [spo locate] and update	been picked up walking the freeway to get home to [name of city]. ouse] lives there. ATL [attempt to d description entered[Resident 1] located[resident 1] was need over to [facility staff member's ree."				
	RESIDENT 3					
	disapposes that inc	dmitted to the facility on 2/1/02 with lude schizophrenia, alcohol abuse, closed head injury, neurologic defici c 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

Event 1

PRINTED: 5/23/

EPARTM	ENT OF HEALTH	AND HUMAN SERV	ICES	٠		FOR	M APPROVE 2567	
TATEMENT O	ATEMENT OF DEFICIENCIES (XI) PROVIDER/SUPP		/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		465124		B. WING			5/10/02	
AME OF PRO	VIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE			
			125 SOUTH SALT LAK	I 900 WEST E CITY, UT	84104			
(X4) ID PREFIX TAG	ANACHI DEFICIENC	Y MUST BE PRECEEDED BY	FULL	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
F 224 : 0	PLAN OF CORRECTION 4651: E OF PROVIDER OR SUPPLIER DTOWN MANOR SUMMARY STATEMENT OF DEFICIEN (EACII DEFICIENCY MUST BE PRECEEDED REGULATORY OR LSC IDENTIFYING INFORM 1. 5/3/02 at 9:00 AM to 5/9/02 when not resident 3's guardian that the resident we returning. Police were notified 5/4/02 at The resident was AWOL 24 hours beform was located. Review of resident 3's closed medical retrevealed the following: 1. A physician's order dated 2/1/02 doc resident 3 could have LOA privileges were not long term memory and moderately cognitive skills (decisions making poor cues/supervision required). Indicators of disordered thinking were documented a distracted. He was targeted as having difficulty with communication: Sometimes understant adequately to simple, direct communication. Resident 3 was documented as using a			F 224			:	
. 1	resident 3's guardian returning. Police was The resident was A were notified and was located. Review of resident revealed the follow. 1. A physician's or resident 3 could have a documented that reand long term memory cognitive skills (decues/supervision redisordered thinking	n that the resident would ere notified 5/4/02 at 9: WOL 24 hours before that as missing for 6 days but as closed medical recording: der dated 2/1/02 documents to LOA privileges with demission MDS, dated 4 sident 3 had problems who are and moderately improved and moderately improved in the control of the	d not be 00 AM. the police efore he rd on 5/8/02 mented that staff only. /25/02. with short paired delirium and					
	communication: S adequately to simp	ometimes understands (ole, direct communication	on).	:				
	mobility. 3. Review of residundated, documen was an AWOL ris impairment. The included "3, Monitorial Properties of the control of the contro	dent 3's comprehensive ted under problem 3, the per previous history a approach for this care poter residents whereaboutes of AWOL. 5. If residents	plan of care, lat resident 3 ind cognitive lan problem lats frequently	:	•			

grounds; B. Call police ASAP (as soon as possible); C. Notify RN/DON or Admin. , also family and/or

successful in AWOL; A. Search the facility &

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION TATEMENT OF DEFICIENCIES (XI) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING C B. WING 5/10/02 465124 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 125 SOUTH 900 WEST MIDTOWN MANOR SALT LAKE CITY, UT 84104 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG F 224 Continued From page 35 F 224 i 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...."

DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 5/10/02 465124 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 125 SOUTH 900 WEST SALT LAKE CITY, UT 84104 MIDTOWN MANOR PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 224 Continued From page 36 **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 If continuation sheet 37 of Event I

DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING \mathbf{C} B. WING 5/10/02 465124 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 125 SOUTH 900 WEST MIDTOWN MANOR SALT LAKE CITY, UT 84104 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE PREFUX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 224 Continued From page 37 F 224 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", 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. If continuation sheet, 38 of Facility ID: UT0053 ATG112000 Event I 10Y111 CMS-2567L

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVE 2567 HEALTH CARE FINANCING ADMINISTRATION (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 5/10/02 465124 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **125 SOUTH 900 WEST** SALT LAKE CITY, UT 84104 MIDTOWN MANOR PROVIDER'S PLAN OF CORRECTION ID SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 224 Continued From page 38 F 224 ! 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....

CMIS-2567L

ATG112000

"[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

> Event I 10Y111

Facility ID: UT0053 If continuation sheet, 39 of

HEALTH CARE FINANC: TATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/IDENTIFICATION NUM		TIPLE CONST	TRUCTION		
· ·	465124	B. WING			C 5/10/02	/10/02
IAME OF PROVIDER OR SUPPLIE		STREET ADDRESS, CITY,	STATE, ZIP C	CODE		
MIDTOWN MANOR		125 SOUTH 900 WES SALT LAKE CITY, U	ST JT 84104			
				PROVIDER'S PLAN OF CORRE	CTION	(X5)
(EACH DEFICE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEEDED BY OR LSC IDENTIFYING INFORMA	FULL PREFIX	(I CR	EACH CORRECTIVE ACTION SH ROSS-REFERENCED TO THE APP	IOULD BE	COMPLETI DATE
F 224 Continued From p	page 39	F 224				!
get her to give n	ne some assistance while the	search				
was being condu	icted"		:			:
"[Employee 1-charge nurse on duty] was very			i			
"[Employee 1-c	harge nurse on duty] was ve and at one point I had to ask	him if he				
uncooperative, a	esident 4] was found. [Emp	loyee 1]	4			
cared at all if [resident 4] was found. [Employee 1] did not seem to care and went about other business,		ousiness,				
refusing to give me assistance"						
INCIDENT OF LICENSED NU	POTENTIAL ABUSE BY IRSE	A				
1 Review of a	police report dated 3/12/02	, obtained				
by the survey to	am on 5/13/02 revealed the	following		,		
concerning alle	gations of neglect by a facil	ity licensed				
charge nurse (E	imployee 1):			*		
Wandad to	the scene to set up an incid	ent post on		•		
1 responded to	on. I was advised that the nu	irse who				
was in charge [employee 1] was in the bath	troom and				
had been for o	ver one hour. [Employee 1]	was				
supposed to be	able to give us details abou	t the	:			
missing person	. I waited for approximatel	y 30 minutes				
after I had arm	ved and then finally knocked hroom announcing myself a	nd for				
door of the bal	o come out"	101				
(employee 1)	o come out					
"When Jemplo	yee 1] came out he was exc	ited, jumpy				
and could not	stand still. His eyes were pi	n point and	:			
his behavior a	gitated. I felt he was on a co	ontrolled	;			
substance but	could not determine what it	was, lasked				
if [employee]] was high and [employee 1]	j aia not said that it		**		
respond. I asl	ked again and [employee 1] intry and he could take anyth	hino he				
was a tree cou	issis y asia sic coura take anya	·····e ···				

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

Event 1

DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING C B. WING 5/10/02 465124 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 125 SOUTH 900 WEST SALT LAKE CITY, UT 84104 MIDTOWN MANOR PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES 1D COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE PREFLX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG F 224 F 224 : Continued From page 40 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. 1 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 If continuation sheet 41 of 11T0053 10Y111 Facility ID: ATG112000 Event 1 CMS-25671

DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 5/10/02 465124 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 125 SOUTH 900 WEST SALT LAKE CITY, UT 84104 MIDTOWN MANOR PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG F 224 F 224 | Continued From page 41 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 If continuation sheet 42 of Facility ID: UT0053 Event 1 CMS-2567L

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

CMS-2567L

(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C B. WING 5/10/02 465124 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 125 SOUTH 900 WEST MIDTOWN MANOR SALT LAKE CITY, UT 84104 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX DATE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 224 Continued From page 42 F 224 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: If continuation sheet 43 of UT0053 ATG112009 Event I Facility ID:

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 5/23/ FORM APPROVE 2567

TOURICINIC	A DIMINISTRATION			
HEALTH CARE FINANCING	ADMINISTICTION			1,
TATEMENT OF DEFICIENCIES	(XI) PROVIDER/SUPPLIER	CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ND PLAN OF CORRECTION	IDENTIFICATION NUM	IBEK:	A. BUILDING	c
	465124		B. WING	5/10/02
			THE PARTY OF THE P	
IAME OF PROVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STATE, ZIP CODE	
AME OF TROTIDEN		125 SOUTH	900 WEST	

IIDTOWN I	MANOR	SALT LAKE CITY, UT		<u> </u>
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUR REGULATORY OR LSC IDENTIFYING INFORMATION	JLL PREFIX ON) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETE DATE
F 224 Co	ontinued From page 43	F 224		: : : :
"(at	Our facility will not permit residents to be suluse by anyone, including staff"	abject to		
ori D w re a S () in	should any employee witness abuse (in any she is required to report it immediately. A abuse must be reported to the Administrate irector of Nursing, or Social Services, who ill report it to the Administrator as well as tesident's representative (sponsor), The State and Certification Department, and Adult Professional law enforcement within twe 24) hours of the occurrence in such incident mediate investigation will be conducted by dministrator and/or his Designee. The finding uch investigation be reported and faxed to the state Survey and Certification Department, we	in turn to the Survey tective enty-four An y the ings of he The within five		
,	5) working days of occurrence of such incic. When an allegation is staff to resident abusemployee will be placed on L.O.A. until investoemplete."	e, the		: :
	The facility's Abuse Reporting, Prevention a Investigation Policy does not define what no how the facility will identify, investigate or incidents of neglect. Neglect is defined as f provide goods and services necessary to ave physical harm, mental anguish, or mental ill	report failure to		
!	4. On 5/14/02, a review of the contents of a in-service, dated 1/9/02, regarding "Review policy" revealed the following documentati	of abuse		
	"Definition of Abuse: A violation of the rig dignity, and worth of individuals. Everything passive abuse (ignoring someone who is de you) to active abuse (hitting someone) E Types of AbusePassive Abuse: Abandor	ependent on examples of		

CMS-2567L

ATG112900

Event 1 10Y111 Facility 1D: UT0053

If continuation sheet 44 of

DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

TATEMENT IND PLAN OI	OF DEFICIENCIES F CORRECTION	(XI) PROVIDER/SUPPLIER IDENTIFICATION NUM		A. BUILDIN B. WING		
	OVIDER OR SUPPLIER	100124	STREET ADDR 125 SOUTH SALT LAK	1 900 WEST	ΓΑΤΕ, ZIP CODE Γ	
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIE. CY MUST BE PRECEEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETE DATE
F 224	Continued From page neglect – Refusal o obligation such as p services"	e 44 r failure to fulfill a caret provision of food or med	aking	F 224		
	483.13(c)(1)(ii) ST RESIDENTS	AFF TREATMENT OF	. :	F 225	F-225	
	been found guilty of mistreating reside finding entered int concerning abuse, or misappropriation knowledge it has of an employee, which service as a nurse State nurse aide resident.	ot employ individuals we of abusing, neglecting, of ints by a court of law; or of the State nurse aide reg- neglect, mistreatment of on of their property; and of actions by a court of latch would indicate unfitneraide or other facility state egistry or licensing author	r have had a gistry fresidents report any against ess for ff to the orities.		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
	involving mistreat injuries of unknow resident property administrator of the accordance with	ment, neglect, or abuse, or source and misappropare reported immediately ne facility and to other of State law through establiding to the State survey a	including priation of y to the fficials in ished		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	:
The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigat is in progress. The results of all investigations must be reported to the administrator or his designated representative a to other officials in accordance with State law		nd must investigation eported to entative 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 give	ed.	
	(including to the agency) within 5	in accordance with State State survey and certific working days of the inction is verified appropria	ation rident, and if		definitions of various types of abuse,	

5/10/02

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 A. BUILDING

(X3) DATE SURVEY COMPLETED

465124

B. WING

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

MIDTOWN MANOR

125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

		•	_	,			
					DEFICIENCY)		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	i	TAG	1	CROSS-REFERENCED TO THE APPROPRIATE	:	DATE
PREFIX	(EACH DEFICIENCY MUST BE PRECEEDED BY FULL	;	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE	:	COMPLETE
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		1D	:	PROVIDER'S PLAN OF CORRECTION	:	(X5)

F 225 : Continued From page 45 action must be taken.

F 225

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

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 OA 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

CMS-2567L

ATG112000

Event 1 10Y111

Facility ID: UT0053 If continuation sheet 46 of

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 5/10/02 465124 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 125 SOUTH 900 WEST MIDTOWN MANOR SALT LAKE CITY, UT 84104 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX PREFEX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 225 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..." The Administrator has coordinated this (3.) "...All reports of abuse must be reported to the effort with the Director of Nursing who will Administrator, or Director of Nursing, or Social monitor the procedure and be responsible Services, who in turn will report it to the Administrator that this plan is followed. The director of as well as to the resident's representative (sponsor), nursing will make a follow up report at the The State Survey and Certification Department, and 6/8/02 Quarterly Quality Assurance Meetings. Adult Protective Services or local law enforcement These reports will not only include that within twenty-four (24) hours of the occurrence of such incident. An immediate investigation will be Policy and Procedure have been followed, conducted by the Administrator and/or his Designee. but also any recommendations for The findings of such investigation will be reported and improvement will be reviewed and faxed to The State Survey and Certification implemented if warranted. Department, within five (5) working days of occurrence of such incidents." DON/ 10T will meet weekly x + month The facility's Abuse Reporting, Prevention and Investigation Policy does not define what neglect is, or then everymonth 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:

Event I

Facility ID:

19Y111

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (XI) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C B. WING 5/10/02 465124 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **125 SOUTH 900 WEST** MIDTOWN MANOR SALT LAKE CITY, UT 84104 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES lD (X5) (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 225 Continued From page 47 F 225 "...(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

10Y111

Event 1

	T OF DEFICIENCIES DF CORRECTION	(XI) PROVIDER/SUPPLIER IDENTIFICATION NUM 465124		(X2) MULTIPI A. BUILDING B. WING	LE CONSTRUCTION	(X3) DATE COMPL	
NAME OF R	ROVIDER OR SUPPLIER	1 400124	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		70/02
	VN MANOR		125 SOUTI	I 900 WEST E CITY, UT			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY SCIDENTIFYING INFORMA	FULL.	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
F 225	evidence the facility notified the police with 1/7/02 at 7:30 AM: [hospital] to inquire eleft in a cab" Ther evidence the facility resident was AWOL hospital. 3/6/02 from 1800 to noted by CNA [certiand facility [without absence] book or infoffice [Social Service place of residence to note did not docume determined to be AW notified.	attempted to locate reshen the resident disapp "Pt still AWOLCalle of Pt whereabouts. The ewas no documentatio notified the police that after being released from 10600 [5:00 PM to 6:00 fied nurse aide] to have signing out in LOA [1 forming staff. Social We representative] containform her of event." In the actual time the revOL or if the police has "Administrator notified."	eared. ed y said he n found to the om the AM[: "Pt e left room eave of orker cted [at] The nurses esident was d been	F 225			
	notifiedPolice will AM." There was no determine when the regarding resident be	call back facility later further documentation police returned the facieing AWOL.	on this found to lity's call				
	[5:30 AM]. Didn't a nurse. Still hasn't re	"Pt has been gone since sign out. Didn't report turned to facility" The police were notified DL.	to this here was no				
-	to report missing Pt.	"Put in a call to police Waiting for officer to nd 30 minutes after the t 2 was AWOL.	call back."				
		iew of police reports, of the following docume					

DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 5/23/ FORM APPROVE 2567

STREET ADDRESS, CITY, STATE, ZIP CODE 125 SOUTH 900 WEST SALT LAKE CITY, UT 84104 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (FACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	TATEMENT ND PLAN O	OF DEFICIENCIES F CORRECTION	(XI) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION	(X3) DATE: COMPL			
PREFIX TAG 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 murse who called the police. [Name of Nurse-employee 2] called the police after tresident 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] past works as the facility. She said she saw [resident 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.				STREET ADDRESS, CITY, STATE, ZIP CODE 125 SOUTH 900 WEST						
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] has 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.	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEEDED BY	FULL	PREFIX	(EACH CORRECTIVE A CROSS-REFERENCED TO	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE		
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"	F 225	Police report dated 3 that the incident regal 3/6/02 at 11:55 PM the facility, on 3/7/0 Police report dated 4 "I was dispatched to case. I talked to the [Name of Nurse-emglesident 2] had been stated [resident 2] had been said she saw [resident 5 the police were said because [resident 2] had been said because [resident 3] why the police were said because [resident 4. Review of the Stevidenced there was had reported the AV 1/6/02, 3/6/02, and RESIDENT 5 Resident 5 was admediagnoses of schizodinsulin dependant of Resident 5's medical states of the can order, dated 8/1	a/7/02: The report document of the port of the polyce 2] called the polyce 3] who works at the fint [resident 2] in the 3] who works at the fint 2] yesterday morning [name of street] walking sked [employee 2 and not called then. [Employee 2] always leaves, but discovered the polyce 2 and not called then. [Employee 3] always leaves, but discovered the polyce 3 and not called then. [Employee 4] always leaves, but discovered the polyce 3 and polyce 4/1/02.	red on police, by later). cumented, sing person olice. lice after lif. She he facility in he building. facility. She gat 0545 high towards employee 3] loyee 2] the always ords the facility dent 2 on 8/15/00 with lar type, pertension. on 5/10/02.						

DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING \mathbf{C} B. WING 5/10/02 465124 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 125 SOUTH 900 WEST MIDTOWN MANOR SALT LAKE CITY, UT 84104 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEEDED BY FULL COMPLETE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 5/23/ FORM APPROVE

TATEMENT IND PLAN C	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MULTIPI A. BUILDING B. WING	LE CONSTRUCTION	(X3) DATE COMPL	ETED C
		465124	STREET ADDR	ESS, CITY, STA	TE ZIP CODE	1 5	/10/02
	ROVIDER OR SUPPLIER	·	125 SOUTH				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEEDED BY R LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(XS) COMPLETE DATE
	report found of a ce 12:35 AM, regardided. 4. Review of the Sevidenced there with had reported the A 11/25/01 and 12/1 RESIDENT 7 Resident 7 was addiagnoses that inclivation with behaviors, Scientification, hypertension of the following docume "0755 [7:55 AM] [residents and state that resident was a facility [and] up [administrator] not service] notified." 2. Review of the evidenced there we had reported the A 3/2/02. RESIDENT 1	sports were reviewed ther all from the facility on 12 ng resident 5 going AWC state Survey Agency recors no documentation that WOL incidents for reside 5/01. Initial to the facility on 3 had a dementia Alzheim guamous cell carcinoma, or sion and anemia. In of the medical record for owing documentation. In the stated 3/2/02, reveale not in the unit searched are and down the block police of fresident taking of the State Survey Agency records no documentation that AWOL incident for reside AWOL incident for resident taking the state of the state	e was no 1/15/01 at DL. rds the facility ent 5 on /1/02 with er's type diabetes or resident d the nit] d] noticed ound the ce notified off ss [social ords the facility ent 7 on	F 225			
		42 year old male resident te following diagnoses: tra					

head injury, severe cognitive deficit with aggressive

10Y111

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVE HEALTH CARE FINANCING ADMINISTRATION (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 5/10/02 465124 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 125 SOUTH 900 WEST MIDTOWN MANOR SALT LAKE CITY, UT 84104 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5)COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 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

CMS-2567L

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVE HEALTH CARE FINANCING ADMINISTRATION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 5/10/02 465124 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 125 SOUTH 900 WEST MIDTOWN MANOR SALT LAKE CITY, UT 84104 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 225 Continued From page 53 F 225 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 5/23/ FORM APPROVE

2567

TATEMENT	OF DEFICIENCIES
	CORRECTION

NAME OF PROVIDER OR SUPPLIER

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

> \mathbf{C} 5/10/02

465124

STREET ADDRESS, CITY, STATE, ZIP CODE

B. WING _

125 SOUTH 900 WEST

MIDTOW	'N MANOR	SALT LAKE CITY, UT 84104					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY I REGULATORY OR LSC IDENTIFYING INFORMAT	FULL P	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED 1 DEFICE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE	
F 225	Continued From page 54 3. In an interview with a social service representation on 5/9/02 at 1:00 PM, she stated that resider guardian called the facility on 5/9/02 stating resident 3 had been located at his previous a Idaho (6 days after resident 3 went AWOL) was no documentation in resident 3's medical indicate that there had been any further investigation of the facility to locate resident 3. There we documentation found to indicate that the includent reported to the State Survey Agency.	esentative, int 3's that iddress in There al record to estigation as no	225				
	RESIDENT 4	:	:			:	
	Resident 4 was admitted to the facility on 1 diagnoses that include dementia with depresentatives and behaviors secondary to trauma injury, hypertension, non-insulin dependant prostate cancer, and colon cancer.	ssive itic brain	· :				
	Review of resident 4's closed medical recon revealed the following:	rd on 5/9/02	!				
	Resident 4 was admitted directly to the NE admission. Nursing notes documented that was moved to the open unit on 3/1/02.	OU on t resident 4	:				
	1. A nurses note, dated 3/12/02 at 7:25 PM documented "CNA reported pt. is not in his search made of facility, unable to locate pt building. Unable to locate pt outside of bl (building) or surrounding areaCall place [police]". At 7:50 PM the nurse document police officer was in the facility.	is room, t. in ldg.		•••			
	At 8:45 PM the nurse documented that res found in the NDU and the police were not	sident 4 was tified.					
	2. On 5/14/02, a review of the police repo 3/12/02, regarding a missing resident, res	ort, dated ident 4,					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVE HEALTH CARE FINANCING ADMINISTRATION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING \mathbf{C} B. WING 5/10/02 465124 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 125 SOUTH 900 WEST SALT LAKE CITY, UT 84104 MIDTOWN MANOR PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5)(X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 225 F 225 | Continued From page 55 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

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVE HEALTH CARE FINANCING ADMINISTRATION 2567 (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (XI) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 5/10/02 465124 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 125 SOUTH 900 WEST MIDTOWN MANOR SALT LAKE CITY, UT 84104 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5)(X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 225 F 225 | Continued From page 56 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 i 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	(XI) PROVIDER SUPPLIER IDENTIFICATION NUM		(X2) MULTIPI A. BUILDING B. WING	LE CONSTRUCTION	— · COME	E SURVEY PLETED C 5/10/03
	465124	STREET ADDRE	SS CITY STA	TE ZIP CODE	L	5/10/02
NAME OF PROVIDER OR SUPPLIER MIDTOWN MANOR	İ	125 SOUTH SALT LAKE	900 WEST			
DREETY (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
reported alleged abusemployee I was sent in the police report, hot sent home. The Distayed at the facility observed the actions that he left the facility that employee I was and residents from morning. When asked if the facility of the property of the investigation into the member stated that the allegations. The DON stated that facility on an as need week. He stated that complaints from the job performance after incident. The DON the facility periodical working, to check or The SS staff member continued complaint administrator had deemployee I screened. When asked if the facility administrator had deemployee I screened. The SS staff member drug screen, the SS staff member drug screen, employ facility.	in the same manner as e. The DON was aske home that evening as we stated that employee DON stated that he (the antil around midnight a of employee 1. The DO at around midnight. Left alone in charge of idnight until 6:00 AM callity had conducted an possible neglect, the Same facility had not invested basis, approximated the facility continued residents regarding emore the 3/12/02 missing restated that he would could be a might be membered by the employee 1 is a composed from the residents the cided that the facility same from the residents the cided that the facility is for controlled drugs. If or controlled drugs, callity had a copy of the member obtained a copy of the member obtained a positive restated because of the eel was no longer works advised, by police of the stated because of the eel was no longer works.	s she d if vas implied one was DON) had and ON stated He stated the staff the next as S staff stigated the or the dy 2 times a to get ployee I's resident ome in to was formance. the chould have de drug by of the results. positive rking at the	F 225			

CMS-2567L

Event 1 10Y111

DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

(X3) DATE SURVEY COMPLETED

> C 5/10/02

465124

B. WING ______
STREET ADDRESS, CITY, STATE, ZIP CODE

125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

MIDTOWN MANOR

NAME OF PROVIDER OR SUPPLIER

PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG F 225 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

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.

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

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.

CMS-2567L

ATG112000

Event 1 10Y111

Facility ID: UT005:

If continuation sheet 59 of

DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 5/23/ FORM APPROVE 2567

TATEMENT (ND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER. IDENTIFICATION NUM 465124	IBER:	A. BUILDING B. WING	3	(X3) DATE SURV COMPLETED C 5/10/)
IAME OF PRO	OVIDER OR SUPPLIER				ATE. ZIP CODE		
	n manor		125 SOUTH SALT LAK		84104		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(XS) COMPLETE DATE
F 225	6. The DON was in The DON stated that documentation of the AWOL events in the complete a facility in the incident or invested events for residents.	terviewed on 5/9/02 at the charge nurse shou is investigation and repersidents medical reconcident report. When a stigation reports for the the DON stated he wall the nurse must not ha	ld complete orting of all ord and also asked for AWOL s unable to	F 225			
F 226 SS=K	483.13(C)(1)(i) ST RESIDENTS	AFF TREATMENT O	F	F 226	F-226	:	
	policies and proce neglect, and abuse of resident propert	evelop and implement dures that prohibit mist of residents and misap y ciencies concerning the implementation of polic	reatment, propriation : facility's		Resident 1 has been assess appropriate placement on the the proper procedure having and reviewed by the independent of the NDU policy will be followed for continued.	ne NDU with g been followed ndent and procedure	
	Based on medical	ENT is not met as evic	of the		Resident 2 has been discha		6/8/02
	that the facility fa	and staff interview it wa iled to develop and imp nd procedures that proh nts with AWOL (absent	olement libited neglect		Resident 4 has been discha		
	leave) behaviors.	Residents: 1, 2, 3, 4, 5	5 and 7.	!	Resident 5, who is not on to been evaluated and receive requirements that are less	ed new LOA	
	and Investigation	acility's "Abuse Reporti Policy" and "Missing I reviewed and stated:	ng, Preventio Patient	: n	was reviewed by Valley Me QA Committee and the res	ntal Health, the	
	1. Abuse Report	ting, Prevention and Inv	estigation:	:			

PRINTED: 5/23/ DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVE 2567 HEALTH CARE FINANCING ADMINISTRATION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C B. WING 5/10/02 465124 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 125 SOUTH 900 WEST MIDTOWN MANOR SALT LAKE CITY, UT 84104 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 226 Continued From page 60 F 226 It is the policy of this facility that reports of abuse will Resident 7 has been discharged. be promptly reported and thoroughly investigated. Policy Interpretation and Implementation: All current residents' LOA requirements (1.) Our facility will not permit residents to be have been reviewed and updated. New subjected to abuse by anyone, including staff members, other residents, consultants, volunteers, staff Admissions will be reviewed by IDT team. of other agencies serving the resident, family members, legal guardians, sponsors, friends, or other To protect other current residents, and to individuals. have an ongoing plan that protects any new (2.) To assist our facility in defining incidents of admissions the facility has implemented a abuse, the following information is provided: A. new protocol and procedure to ensure that Verbal abuse...B. Sexual abuse...C. Physical the location of residents are monitored abuse...D. Involuntary seclusion is defined as separation of a resident from other residents or from and, that if missing or AWOL, a procedure his or her room against the resident's will, or the will to locate and report the situation. The of the resident's legal guardian or representative attached policy and procedures have been (sponsor). (Note: Temporary monitored separation implemented. Training of personnel and from other residents will not be considered involuntary ongoing training for new personnel and seclusion and may be permitted when used as a 6/8/02 review for current employees have been therapeutic intervention to reduce agitation as determined by the medical director, and/or director of initiated. Specific inservices have been nursing services, such as action that is consistent with held and "spot" checks of employees the resident's plan of care.) E. Mental abuse... demonstrating that they have learned and (3.) Should any employee witness abuse (in any form) understand the training that has been he or she is required to report it immediately. All. given has been accomplished. All work reports of abuse must be reported to the Administrator. shifts have been covered with regard to this or Director of Nursing, or Social Services, who in turn training. A brief overview of the training will report it to the Administrator as well as to the resident's representative (sponsor), The State Survey includes: A time frame that each care giver and Certification Department, and Adult Protective or employee who is responsible for a Services or local law enforcement within twenty-four (24) hours of the occurrence of such incident. An

CMS-2567L

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."

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 5/23/ FORM APPROVE 2567

HEALTH CARE FINANCIN	IG ADMINISTRATION			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		
MIDTOWN MANOR		125 SOUTH 900 WEST		

(X3) DATE SURVEY COMPLETED

C 5/10/02

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

DEFICIENCY)

F 226

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

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

If continuation sheet 62 of

PRINTED: 5/23/ DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVE HEALTH CARE FINANCING ADMINISTRATION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 5/10/02 465124 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 125 SOUTH 900 WEST MIDTOWN MANOR SALT LAKE CITY, UT 84104 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5)(X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 226 F 226 | Continued From page 62 with diagnoses of paranoid schizophrenia, cognitive disorder with behaviors, depression, suicidal ideations, Inservices on the above procedures were. insulin dependant diabetes, and polysubstance and given on May 11th; May 13th; May 14th; May alcohol abuse. 15th; & May 30th. All shifts, and all Resident 2's medical record was reviewed on 5/7/02 personnel received this inservice. and documented the following: The inservice was given by the Administrator and Social Services. Follow 1. The nurse's notes were reviewed for the time period up training will be done for review of of 5/31/01 through 4/2/02. Documentation included current employees, and orientation for new the following: employees. The schedule for ongoing 1/6/02 at 6:00 PM: "Pt [patient] refused review of the policy and procedure is a [medication]...took at 18:40 [6:40 PM] and then mandatory employee meeting on the third disappeared..." There was no documentation found to Friday of each month. 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 leavel...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 This will be monitored by the Director of noted by CNA [certified nurse aide] to have left room Nursing and part of his report at the and facility [without] signing out in LOA [leave of 6/8/02 **Ouarterly Quality Assurance Meetings.** absence] book or informing staff. Social Worker However, the initial implementation of the office [Social Service representative] contacted [at] plan was reviewed at a Quality Assurance place of residence to inform her of event." The nurses Committee Meeting on June 4, 2002 to note did not document the actual time the resident was insure that viable plan had been placed determined to be AWOL, if the facility staff had attempted to locate the resident, or if the police had into effect.

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

DON/10T will monitor at weekly meetings XT month then mon-thly there after.

been notified.

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (XI) PROVIDER/SUPPLIER IDENTIFICATION NUM 465124			(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 5/10/02		
AME OF PROVIDER OR SUPPLIER STREET			STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
	'N MANOR			H 900 WEST KE CITY, UT	84104		i
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
F 226 Continued From page 63 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			F 226				
	documentation found	nurned to facility" The to evidence the facilities ident 2 or notified the DL.	ty staff	:			
	to report missing Pt.	"Put in a call to police Waiting for officer to and 30 minutes after the 2 was AWOL.	call back."				•
	2. On 5/13/02 a revealed 4/2/02, Concern revealing the follow:	iew of police reports, d ing Resident 2 was cor ing documentation:	lated 3/7/02 iducted	- - -			
	that incident regardi 11:55 PM and was r	8/7/02: The report doc ng resident 2 occurred eported to the police, b 6:54 AM (7 hours late	on 3/6/02 at by the				
	said she saw [reside. [5:45 AM]. He was [name of street]. I a why the police were	e 3] who works at the ant 2] yesterday morning [name of street] walkinsked [employee 2 and not called then. [Employee 2] always leaves, but 2] always leaves, but deds.	g at 0545 ng towards employee 3] bloyee 2]				
	medical record that Reporting, Preventi Missing Patient pol- implement a search manner when the re	cumentation found in r the facility followed th on and Investigation po- icy. The facility failed or notify the police in sident was identified as notify the attending ph	eir Abuse olicy or their to a timely s being				

Event I JOY111

EPART	MENT OF HEALTI	H AND HUMAN SERV	ICES			FORM	M APPROVE 2567
HEALTH CARE FINANCING ADMINISTRATION TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (XI) PROVIDER/SUPPLIER IDENTIFICATION NUM		WCLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		465124		B. WING		5,	/10/02
VE OF DD	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STAT	E, ZIP CODE		
	N MANOR		125 SOUTH SALT LAKI	900 WEST E CITY, UT 8	4104		
(X4) ID PREFIX TAG	- SUMMARY S	STATEMENT OF DEFICIENCIE CY MUST BE PRECEEDED BY R LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(XS) COMPLETE DATE
F 226	Continued From pag the State agency.	e 64		F 226			
	RESIDENT 5	•	ļ !	1			
	diagnoses of schiz	mitted to the facility on 8 oaffective disorder bipol diabetes mellitus and hy	lar type,				
	The resident's med 5/10/02.	lical record was reviewe	d on			·	
	1. The nurse's not revealed the follow	es for resident 5 were re wing:	viewed and				
	take 11/25/01 noc time was docume resident was AWG found regarding t resident or that the determined the re	AM: "Yesterday pt was come back at present time (night time) meds." No nted for when the staff nOL. There was no docume staff attempting to lock police were notified was all attempting to sident was AWOL.	e. Does not o specific oted the mentation cate the hen the staff				
	11/27/01 at 7:30 police." This was resident went AV	AM: "Called and report approximately 44 hours WOL.	ed missing to safter the	1			
	attempted to sign could not sign or became belligere informed she wa	O AM: "Pt up at nurse's nout in LOA book. Pt in it for LOA (at) this time. ent, stating she was leaving a not to leave facility + whe facility (at) this time.	nformed she Pt again ng facility. Pt would be		***		
	12/15/01 at 12:3 Lake Police Dep	5 AM: "Call placed to Spartment) to report pt AV	SLPD (Salt VOL.				

the following incident:

2. Review of a police report on 5/13/02 documented

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 5/23/ FORM APPROVE 2567

<u>HEALTH</u>	CARE FINANCING	J ADMINISTRATION					
TATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465124				(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C	
			B. WING		5/	10/02	
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
	VN MANOR		125 SOUTI SALT LAK	H 900 WEST E CITY, UT	84104		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIE Y MUST BE PRECEEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFLX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
F 226	Continued From page	65		F 226			
	the incident regarding at 11:30 AM, and w	as dated 11/27/01, documn resident 5 occurred of as reported by the facility, on 11/27/01 at 8:47	on 11/25/01 ity to the				
	medical record that Reporting, Preventi Missing Patient pol implement a search manner when the re	the facility followed the facility followed the on and Investigation poicy. The facility failed or notify the police in a sident was identified as notify the attending phenomena.	eir Abuse blicy or their to a timely being	,			
	RESIDENT I			:	-		!
	on 8/7/01, with the	2 year old male resident following diagnoses: tr cognitive deficit with a sia (difficulty commun	aumatic iggressive		•		
	documented severa	nurse's progress notes or al episodes of resident 1 without the staff's know	leaving the		· · · · · ·		
	A nurse's note date will go AWOL, se most of the time".	ed 12/24/01, stated: "Or ems to find way back to	occasion facility		: : :		
	Other notes dated, that the resident w	2/4/02 and 2/25/02, do tould go AWOL at times	cumented s.				
	which stated: "Soc previously at [loca abrasion observed	O AM, a nurses note wa cial Services [name] rep al grocery store] and fel on right third finger et d et Band-Aid applied.	orts pt. was l. Small [and] elbow.				1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1

DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 5/23/ FORM APPROVE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A. BUILDING	LE CONSTRUCTION	(X3) DATE S COMPLI		
	465124		B. WING 5/10/0				
NAME OF PI	ROVIDER OR SUPPLIER		t	RESS, CITY, STA	TE, ZIP CODE		
	VN MANOR			1 900 WEST E CITY, UT			
(X4) ID PREFIX TAG	(FACH DEFICIENC	TATEMENT OF DEFICIENCIE Y MUST BE PRECEEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
F 226	Continued From page	66		F 226			
	stated: "Pt AWOL f City Police Departm 5:00 PM, eight hour missing, the nurse d returned to facility - airport - pt. placed i locked unit for more AWOL behavior - v Family notified".		salt Lake same day, at loted as ng: "Pt. [Salt Lake] ons Unit] - nt due to monitor. otes on				
	staff member wrote	ssion 08/7/01, the social the following: "Staff w. &/or aggressive behave."	vill monitor				
	on NDU for structu AWOL from facilit to being a danger to it to the airport and	tes stated: "Resident rec ire environment due to ty numerous times. Pos o self. Resident success I was brought back by the of his surrounding an	going ses himself sfully made he police.				
	3. Review of the b	pehavior data collection e following episodes of	sheets on AWOL:				
	2 during the month 2 in February 200 1 episode in April in the NDU.	n of January 2002, 12, 6 in March 2002, an 2002 (after the residen	d t was placed				
	4. Review of the completed on 5/8/	Care Plan Conference S 02 documented the foll	Summaries owing:				
	Review of the Car	e Plan Conference Sum	mary for	:	1	•	

DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING \mathbf{C} B. WING 5/10/02 465124 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **125 SOUTH 900 WEST** MIDTOWN MANOR SALT LAKE CITY, UT 84104 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE DATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG F 226 Continued From page 67 F 226 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

DEPART	MENT OF HEALTH	AND HUMAN SERV	ICES				1 APPROVE 2567
HEALTH CARE FINANCING ADMINISTRATION TATEMENT OF DEFICIENCIES (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465124		/CLIA MBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED C 5/10/02		
	ROVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STAT	E, ZIP CODE		
	VN MANOR		125 SOUTH SALT LAK	I 900 WEST E CITY, UT 8	4104		· · · · · · · · · · · · · · · · · · ·
(X4) ID PREFIX TAG	SUMMARY S	TATEMENT OF DEFICIENCIE CY MUST BE PRECEEDED BY LSC IDENTIFYING INFORMA	' FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
F 226	station], but he has: know [resident 1]. band with his name [number] on it. [Resident 1 has be [in the past], trying [Resident 1's] [spo locate] and update was subsequently returnedand turn name], an employ 8. Review of the evidenced there we had reported the were documented 3/11/02. The beh AWOL's in Janual 2 in February 200 April 2002 (after Details of the inc data sheets were or social services 9. The facility fa and investigation Survey and Certi twenty-four (24) incident". There investigation of a unsupervised vis	Resident I has a permanent and the [facility's] photoseen picked up walking to get home to [name of use] lives there. ATL [addescription entered[located[resident I] was ded over to [facility staff wee." Utah States Agency recommendation that work incidents for resident he nurse's notes on a vior data collection she ry 2002, 12, 6 in March 2002, and the resident was placed idents documented on the not documented further inotes. Italied to follow their abust policy by not reporting fication Department with hours of the occurrence was no documentation all AWOL resident I's first to a local grocery stots were not aware of residents was resident aware of residents was resident of the securior of the securi	the freeway of city]. attempt to Resident 1] s member's ords at the facility dent 1 which 3/09/02 and eets noted 2 d 1 episode in in the NDU). he behavior in the nurses he reporting to the "State hin of such of a thorough requent ore. The sident 1's				
	whereabouts at a responsibility in	all times as was outlined the policy.	us mon				

RESIDENT 3

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES TH CARE FINANCING ADMINISTRATION

PRINTED: 5/23/ FORM APPROVE

(X5)

COMPLETE

HEALTH CARE THAT		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. RUILDING
	ļ	l r wing

465124

(X3) DATE SURVEY COMPLETED

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE

CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

C 5/10/02

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ID

PREFLX

TAG

F 226

125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

(X4) ID

PREFIX

TAG

F 226

Continued From page 69 diagnoses that included schizophrenia, alcohol abuse, seizure disorder, closed head injury, neurologic deficit and post traumatic stress disorder.

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION)

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

Facility ID:

UT0053

If continuation sheet 70 of

DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 5/23/ FORM APPROVE

(X5) COMPLETE DATE

	-
TATEMENT OF	DEFICIENCIES
NO BLANCEC	

(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

 \mathbf{C} 5/10/02

465124

B. WING STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF PROVIDER OR SUPPLIER		125 SOUTH 900 WEST SALT LAKE CITY, UT 84104					
(X4) ID PREFIX TAG	PREFIX RECULATORY OR LISC IDENTIFYING INFORMA		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 226	F 226 Continued From page 70 Agency as potential neglect.		F 226	۸.			
	6. The facility failed to follow their "Missi Procedure" The staff was unaware of the rewhereabouts at all times and when the resid found missing, did not conduct an immediathorough search of the facility and neighbor administrator and or director of nursing did						

RESIDENT 4

the health department.

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.

to the facility and assume responsibility for the search and notify outside agencies including the police and

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.

Event 1

If continuation sheet 71 of

10Y111

(X3) DATE SURVEY

DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING \mathbf{C} B. WING 5/10/02 465124 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **125 SOUTH 900 WEST** MIDTOWN MANOR SALT LAKE CITY, UT 84104 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 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 If continuation sheet 72 of ATG112000 Event I 10Y111 Facility ID: UT0053 CMS-2567L

DEPARTMENT OF HEALTH AND HUMAN SERVICES

IEALTH CARE FINANCING ADMINISTRATION (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: ND PLAN OF CORRECTION A. BUILDING B. WING 5/10/02 465124 STREET ADDRESS, CITY, STATE, ZIP CODE AME OF PROVIDER OR SUPPLIER 125 SOUTH 900 WEST MIDTOWN MANOR SALT LAKE CITY, UT 84104 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX DATE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 226 Continued From page 72 F 226 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."

PRINTED: 5/23/ FORM APPROVE 2567

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/S IDENTIFICATION NUMBER SUPPLIER/SUP			(X2) MULTIPE A. BUILDING B. WING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 5/10/02		
		465124		DESC CITY ST	TE ZIR CODE	5	/10/02
	OVIDER OR SUPPLIER ON MANOR		125 SOUTI	RESS. CITY, STA H 900 WEST (E CITY, UT			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TON SHOULD BE THE APPROPRIATE	(XS) COMPLETE DATE
F 226	Continued From page	73	:	F 226			:
	"1100 [11:00 AM] [they had [resident 7] him back"	nospital] called [and] so [and] that they would b	tated that be bringing				
	evidenced there was	ite Survey Agency recond documentation that OL incident for residently policy.	the facility				
	Procedure" by not n and he left the facili	d to follow their "Missi nonitoring resident 7's v ty unattended. The fact cy that the resident was	vhereabouts ility did not				
•	INCIDENT OF PO	ΓΕΝΤΙΑL ABUSE BY Ε	A	! .			
	by the survey team	ce report dated 3/12/02 on 5/13/02 revealed the ons of neglect by a facil oyee 1):	following				
	a missing person. I was in charge [emp had been for over o supposed to be able missing person. I wafter I had arrived a	scene to set up an incide was advised that the nulloyee 1] was in the bath me hour. [Employee 1] to give us details about a details about a details about a then finally knocked me announcing myself a me out"	arse who broom and was at the y 30 minutes d on the		**		
	and could not stand his behavior agitate substance but could	I] came out he was exceed still. His eyes were pied. I felt he was on a coll not determine what it is high and [employee 1]	n point and ontrolled was. I asked	1		· · · · · · · · · · · · · · · · · · ·	

PRINTED: 5/23/ FORM APPROVE

5/10/02

TATEMENT	OF DEFICIENCIES
	CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING

(X3) DATE SURVEY COMPLETED C

465124

STREET ADDRESS, CITY, STATE, ZIP CODE

125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

NAME OF PROVIDER OR SUPPLIER

MIDTOWN MANOR

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

CMS-2567L

ATG112000

Event 1 10Y111

UT0053 Facility ID:

If continuation sheet 75 of

PRINTED: 5/23/

EPARTN	MENT OF HEALTH	I AND HUMAN SERV	ICES			FORM	4 APPROVE 2567
ATEMENT (CARE FINANCING OF DEFICIENCIES FORRECTION	(XI) PROVIDER/SUPPLIER IDENTIFICATION NUM	UCLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C	
	465124			B. WING		5/	10/02
AND OF DR	ME OF PROVIDER OR SUPPLIER		STREET ADDR	ESS. CITY, STAT	E, ZIP CODE		
	N MANOR		125 SOUTH SALT LAKE	900 WEST E CITY, UT 8	34104		
(X4) ID PREFIX TAG	SUMMARY S	TATEMENT OF DEFICIENCIE CY MUST BE PRECEEDED BY LSC IDENTIFYING INFORMA	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
E 226	Continued From page 1]. I came back at the immediate area completely forgotte "[Employee 1] was point I had to ask h was found. He did other business, refu" I had to call [com [employee 1] woul was eventually ask [complainant] arriv 2. On 5/14/02 at 2 facility DON and the DON stated the police when reside When asked if the regarding the safe of employee 1, he concerned with the concerned with the safe with the concerned with th	e 75 bout 10 minutes later aft and it was as though the en about [resident 4]' severy uncooperative, and im if he cared at all if [interest and wasing to give me assistant plainant] to come back id not cooperate, and ented to go home for the newd." 2:05 PM, in an interview the social service (SS) so at he had been the one to tent 4 was found missing a police had voiced their ty of the residents due to stated he felt the police the fact that resident 4 was go than the safety of the resident 4 was go than the safety of the resident 4 was go than the safety of the resident 4 was go than the safety of the resident 4 was go than the safety of the resident 4 was go than the safety of the resident 4 was go than the safety of the resident 4 was go than the safety of the resident 4 was go than the safety of the resident 4 was go than the safety of the resident 4 was go than the safety of the resident 4 was go than the safety of the resident 4 was go than the safety of the resident 4 was go than the safety of the resident 4 was go than the safety of the resident 4 was go than the safety of the resident 4 was go than the safety of the resident 4 was go than the safety of the resident 4 was go than the safety of the resident 4 was go that the safety of the resident 4 was go that the safety of the resident 4 was go that the safety of the resident 4 was go that the safety of the resident 4 was go that the safety of the resident 4 was go that the safety of the resident 4 was go that the safety of the resident 4 was go the resident 4 was go that the safety of the resident 4 was go the resid	er searching ey had d at one resident 4} ent about nce" to work as aployee 1 ight when w with the taff member, o call the concern o the actions were more as found	F 226			
	1, on 3/12/02, du as possible negle service) staff mer	ey identified the actions ring the time resident 4 ct of residents, both the mber and the DON state ed it as possible neglect.	was missing SS (social d that they	i	: - ;		
	The SS staff men she need to repor as she reported a	nber stated that she did at alleged neglect in the lleged abuse.	not know that same manner		**		

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

Event 1

DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

SUMMARY STATEMENT OF DEFICIENCIES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

465124

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE

A. BUILDING B. WING

 \mathbf{C} 5/10/02

(X5) COMPLETE

DATE

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

PREFIX

125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

MIDTOWN MANOR

(X4) ID

(EACH DEFICIENCY MUST BE PRECEEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG F 226 F 226 : Continued From page 76 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

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

member stated that the facility had not investigated the

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

If continuation sheet 77 of

EPARTMI	ENT OF HEALTH	AND HUMAN SERV.	ICES				2567
EALTH CARE FINANCING ADMINISTRATION ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER'S UPPLIER IDENTIFICATION NUM 465124		fBER:	IA (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED C 5/10/02		
ME OF PROV	VIDER OR SUPPLIER	100.22		ESS, CITY, STAT	E, ZIP CODE		
11DTOWN	MANOR		125 SOUTH SALT LAKE	E CITY, UT 8			
(X4) ID PREFIX TAG	ACH DEFICIENCY	ATEMENT OF DEFICIENCIE Y MUST BE PRECEEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	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			F 226				
	continue working af other sources conce facility will not per by anyone, including follow their policy of the incident. Are conducted by the action to the incident of the incident of the incident of the incident. Are conducted by the action to the incident of the incident of the incident of the incident of the incident of the incidents of neglect of the incidents of the incidents of neglect of the incidents	olicy by allowing employer questions from the prining his ability to function tresidents to be subjuggestaff" The facility of reporting abuse (negentification agency with immediate investigation agency with a lowed to work the renging monitored by the directors. He was allowed to a finally drug tested and buse Reporting, Prevery does not define what all identify, investigate out. The staff were not a distituted abuse via negligate it as such.	police and ction: "Our ect to abuse did not lect) to the nin 24 hours on was not gnee. until the facility nainder of ctor of o work more lirector of dismissed.				
F 280 SS=F	1	IDENT ASSESSMEN	Т	F 280	0.		
	•	7 days after the compl	letion of the				:

Prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with

PRINTED: 5/23/ FORM APPROVE

2567

ATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/	CLIA	(X2) MULTII	PLE CONSTRUCTION	COMPLETED		
D PLAN OF	CORRECTION	IDENTIFICATION NUM	BER:	A. BUILDIN		· C	C 5/10/02	
		465124		B. WING		5/10/9		
	OVIDER OR SUPPLIER		125 SOUTH SALT LAK	I 900 WEST E CITY, UT	PROVIDER'S PLAN OF	FCORRECTION	(X5)	
(X4) ID PREFIX TAG	ALL OF DESIGNED	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFLX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETE DATE	
	Continued From page responsibility for the staff in disciplines and needs, and, to the export of the resident, the legal representative Periodically review qualified persons and This REQUIREMI Based on review of IDT (Interdiscipling staff interviews it and the evaluate or review of the evaluate or review of the evaluate or review of the evaluate or review of the evaluate or review in the evaluate or review of the evaluate of t	e resident, and other applies determined by the resident practicable, the paresident's family or the resident's family or the resident's family or the resident's family or the resident and revised by a tear fiter each assessment. ENT is not met as evident from the medical records, remany Team) meeting minutes and that the rise the care plans for 6 sident's status changed. Idmitted to the facility of paranoid schizophrenia aviors, depression, suicit diabetes, and polysubstated in the physician's orders from the following properties or the physician's orders from the following properties or the physician's orders from the following properties or the physician's orders from the following properties or the physician's orders from the following properties or the physician's orders from the physician's orde	propriate ident's rticipation resident's m of enced by: eview of the nutes, and facility did of 8 Residents 1, m 5/31/01 a, cognitive idal ideation stance and ed on 5/7/02. m admission		F-280 Residents' 1 and 5 care updated to reflect residents. Resident 2, 3, 4, and 7 discharged. To insure that the corre on going for current and facility will follow the discorrection regarding and consultant. An additional consultant State, will be hired and review the procedures effectiveness. This coasked to make sure the review and assessment will be effective now a recommendations of included in our overal indicated. This constant of the resident state of the resident s	plans has been ent needs and have been ctive measures are d new residents the irected plan of independent ant, approved by the d directly assigned to we have installed for insultant will also be not the on going int of the procedures and in the future. The the consultant will be ll plan and initiated as	!	
-	Unit). 2. Review of the resident 2 date.	hat the physician gave of aced in the NDU (New the facility's contract agreed 6/13/01, indicated the enter into this agreement	eement with following:		are adequate and ef will submit weekly re	fective. The consultan		

PRINTED: 5/23/ FORM APPROVE

TEMENT PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MULT A. BUILDIN B. WING		COMPLETE C 5/10/	D
	OVIDER OR SUPPLIER		STREET ADDR 125 SOUTH SALT LAK	1 900 WES			
X4) ID PREFIX TAG	(FACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEEDED BY R LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE :	(X5) COMPLETE DATE
F 280	(1). I will have m health caseworker (2). Not use illegal (3). Agree to atte [outpatient mental (4). Agree to have tests done on a modiscretion. (5). Go to Social nurse]/DON [Diredepressed, sad, has have need/desire to the communical comply with the anonal the locked unit to the communical comply with the anonal the locked unit to the communical comply with the anonal the locked unit to the communical comply with the anonal the locked unit to the communical comply with the anonal the locked unit to the communical comply with the anonal the locked unit to the communical to the locked unit to the	y money's managed throw all drugs or alcohol. Individual and alcohol grow health]. It urine and for blood drug antitly basis and for at the Services or RN [register ctor of Nursing] when I we pressure from other recommended of the above I will be all the ty on a daily basis. If I down, I will voluntarily part for self protection." Individual the Social worker on I not sign this form. The atton found in the residence the physician was invocility's contract agreement alth physician's notes, day and the dates of 5/31/01 the protection of the dates of 5/31/01 the protection was an active member of the IDT meeting for the	g screen e staffs red feel esidents, or ohol. lowed to go lo not olace myself ocial Service 6/13/01. re was no nt's medical lived in nt with ated 1/24/02, ut on the ls to 911. " eting minutes rough 4/2/02. e resident 2's er of the IDT	F 280	indicating the findings and progratis/her review. These findings are recommendations will be incorporated Quality Assessment and Assu Committees. Changes in Policy a procedures will be made if indicated these weekly consultant to be forwarded to the State on a web basis. The initial review by the consultatindicated that specific areas requirection from the consultant are Make use of the current alarm. Functional Analysis needs to completed and used in develop new behavior management pland Data collection methods sho qualitative information. Maladaptive Behavior needs specifically stated and described care plans.	orated in arance and ated. A reports will eekly ant guiring e: n system. be ment of as. uld include	6/8/02

PRINTED: 5/23/ FORM APPROVE

TATEMENT	OF DEFICIENCIES
	E CORRECTION

NAME OF PROVIDER OR SUPPLIER

(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

C 5/10/02

465124

B. WING STREET ADDRESS, CITY, STATE, ZIP CODE

F 280

125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

MIDTOWN MANOR

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

COMPLETE DATE

F 280

Continued From page 80

1"... 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] I 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

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.

PRINTED: 5/23/

DEPART	MENT OF HEALTH	AND HUMAN SERVI	CES			FORM	APPROVE 2567
TATEMENT	CARE FINANCING OF DEFICIENCIES F CORRECTION	(XI) PROVIDER/SUPPLIE	CLIA BER:	(X2) MULTIF A. BUILDING B. WING	LE CONSTRUCTION	(X3) DATE SU COMPLET (5/1	ED
	OVIDER OR SUPPLIER	403124	STREET ADDR	900 WEST			
MIDTOW	'N MANOR		SALT LAK	E CITY, UT			<u> </u>
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY I LSC IDENTIFYING INFORMAT	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(XS) COMPLETE DATE
	Continued From page	81	1	F 280			!
r 200	came into the facilit	y, he stated (resident 2) tried to do a suicide in tient was taken to the ho	the middle	ě.			
	1/7/02 at 10:45 AM	: "Pt returned to facility	/"				
	noted by CNA (cer and facility (withou absence) book or in	o 0600 (5:00 PM to 6:00 tified nurse aide) to have it) signing out in LOA (Informing staff. "Pt returned to facility	e left room		The Administrator has co effort with the Director o monitor the procedure a that this plan is followed nursing will make a follo Quarterly Quality Assura	f Nursing who will and be responsible d. The director of ow up report at the	
	assisted from hosp 3/29/02 at 5:00 PM [resident 2] called following him all c [with] a knife - pt. Story not substanti	ital stay." 1: "Police came to desk a and said that [another reover the facility and thread did not notify any of the ated by any witnesses, sed in NDU for more structure.	and stated sident] was atening him	(ave	These reports will not or Policy and Procedure had but also any recommenimplovement will be revimplemented if warrant plans will be will be will be will be will be will be will be will be will be will be will be will be	nly include that ave been followed, dations for riewed and ed.	
	4/1/02 at 3:00 PM (5:30 AM). Didn	: "Pt has been gone sind 't sign out. Didn't report returned to facility"	ce 0530 t to this	Needec change weekly	well as go will be made x + month 4	in 10T m	neeting
	Review of resi evidenced the foll	dent 2's Plan of Care, da owing:	ted 6/13/01,		:		
	"Problem #1: All worsening of chro	eration in behavior r/t [r onic illnessApproach:.	elated to]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.

10Y111

Event 1

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: IND PLAN OF CORRECTION A. BUILDING B. WING 5/10/02 465124 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 125 SOUTH 900 WEST SALT LAKE CITY, UT 84104 MIDTOWN MANOR PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES 1D (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG F 280 F 280 Continued From page 82 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 (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (XI) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C B. WING 5/10/02 465124 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 125 SOUTH 900 WEST MIDTOWN MANOR SALT LAKE CITY, UT 84104 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG F 280 Continued From page 83 F 280 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.

CMS-2567L

ATG112000

Event I 10Y111

Facility ID: UT0053

If continuation sheet 84 of

CMS-2567L

(XI) PROVIDER/SUPPLIER/CLIA

(X2) MULTIPLE CONSTRUCTION

PRINTED: 5/23/ FORM APPROVE 2567

(X3) DATE SURVEY

STATEMENT OF DEFICIENCIES (XI) PROVIDER/SUPPLIE AND PLAN OF CORRECTION IDENTIFICATION NU		VCLIA MBER:	(X2) MULTIPLI A. BUILDING B. WING	E CONSTRUCTION	COMPL	С			
		465124	·			5	/10/02		
	OVIDER OR SUPPLIER		125 SOUTH	ORESS, CITY, STATE, ZIP CODE OREST KE CITY, UT 84104					
(X4) ID PREFIX TAG	CACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEEDED BY PR LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AG CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE		
	AM meds and Ins 6. There was no or medical record the assessed her continuous plan of Care to accomplemented interplemented interplemented interplemented in the behaviors and properties	AM: "Pt returned from A ulin. [No]apparent probled documentation found in reat the facility staff identificated AWOL behaviors, the dress the AWOL behavior ventions to stop the AW of the the resident. 42 year old male resident following driventions to stop the AW of the following driventions and aphasia (difficult Resident 1 was admitted the following form of the followi	esident 5's fied and applated the ors, or OL that admitted to hiagnoses: ficit with lety and to the open re unit). 5/9/02, day of aumatic brain ident is can find his and wanting and wanting and wanting are "No AWOL.						
	Δ note dated 1	1/8/01 stated: "Resident es of going AWOL from i	has had facility,	Facility ID:	UT0053	If co	entinuation sheet 8.		

HEALTH AND HUMAN SERVICES

PRINTED: 5/23/ FORM APPROVE

EPARTN	MENT OF HEALTH	VOITA TTSIMMAN A.	ICEO				2567
<u>ALTH</u>	CARE FINANCING	ADMINISTRATION			CTION	(X3) DATE S	URVEY
IEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER	/CLIA	(X2) MULTIPLE CONSTRUCTION		COMPLE	TED
D PLAN OF CORRECTION IDENTIFICATION NU		IBEK:	A. BUILDING			C	
		445134		B. WING		5/	10/02
		465124	STREET ADDR	ESS CITY STAT	IE. ZIP CODE		
ME OF PR	OVIDER OR SUPPLIER		1				
			125 SOUTH	E CITY, UT	84104		
IDTOW	DTOWN MANOR		SALI LAK	EC111, 61		ODDECTION	i (VI)
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY REGULATORY OR LSC IDENTIFYING INFORM.		FULL ·	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE	
TAG	KEGGEMION OF					· /	
		0.5	1	F 280			
F 280	Continued From page	go home. Resident do	es wear a				!
1	because he wants to	always been brought ba	ack by	i			*]
	ID pracelet and has	s have been posted at fro	ont door to				1
	police safely. Signs prevent him from le	s nave been posted as in	1				1
	prevent him from le	aving facility.	:	İ			į
		ogress note dated 4/18/0	2. stated:	ļ			1
	A social service pro	placed on NDU for stru	cture	ļ			į
	"Resident recently	going AWOL from fac	ility		•		
	environment due to	oses himself to being a	danger to	I I			
	numerous times. P	essfully made it to the	irport and	į			
	self. Resident succ	by police. Resident is u	naware of	į			:
	was brought back t	d whereabouts. Resider	nt has always				•
	his surrounding and	facility and does wear	ID	1			
	agreed to return to	is not adjusting well to	being on				
	bracelet. Resident	an increase in behaviors	s and	· i			:
	NDU and has had	OL when going to activ	/ities +/or	:			•
	attempts to go Aw	esident will continue to	reside on		•		1
	and or mearsRe	environment and for hi	s safety."		•		
	NDU for structure	environment and for in	5 0a.0-y	:	<u>!</u>		:
	a p in afther	nurses notes revealed or	ngoing		; •		
	2. Review of the	L from the date of adm	ission 8/7/01	•	!		!
	incidents of A wo	the resident was placed	in the NDU:				,
	to 3/11/02, when t	ille resident was presse					1
	1	/02, documented the fol	llowing: At		1		:
	A note dated 3/11	VOL family and SLPD	Salt Lake	:			
	9:00 AM. Pt. Av	nt] notified." At 5:00 Pl	M "Pt	1			<u>!</u> !
	Police Departmen	cility - staff located pt. a	at SL airport -				!
	returned to the lat	J - locked unit for more	structured	:			į
	pt. placed in NDC	to AWOL behavior - w	ill cont		,		
	environment due	itor Family notified "	•				
	[continue] to mor	nitor. Family notified."					!
•		9:00 AM and dated 4/1	0/02 a month	1			1
	A note written at	Ainn Wist alin naten 4/1	JDII stated:	•			
	after the resident	was transferred to the N	tom current				i :
	"Pt. agitated - att	empting to go AWOL f	ioni cuitcii				•
1	events activity	•		1	i		:

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

PRINTED: 5/23/ FORM APPROVE 2567

JENE III	
TATEMENT OF DEFICIENCIES	(XI) PROVIDI

NAME OF PROVIDER OR SUPPLIER

ND PLAN OF CORRECTION

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING

(X3) DATE SURVEY COMPLETED C

5/10/02

465124

STREET ADDRESS, CITY, STATE, ZIP CODE

125 SOUTH 900 WEST

HDTOWN MANOR SA		SALT LAKE CITY, UT 84104					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATION	JLL :	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 86 care plan problem was reviewed and continue without change by the IDT on these dates: 8/19/27/01, 11/8/01, 1/31/02, 4/18/02 and 5/02/0 care plan approaches included:	16/01,	F 280				
	"(1). Document all AWOL attempts on data c sheets on a 24 hr. basis.	collection	· !			! !	
	(2). Monitor data collection sheets-report an to RN/DON.	y changes	: :			:	
	(3) Monitor res. whereabouts frequently to dechances of AWOL.	decrease					
	(4). Provide reassurance/redirection as need	led.					
·	 (5). If resident is successful in AWOL = a. Search facility and grounds - announce on system. b. Call police ASAP. [as soon as possible]. c. Notify RN/DON or owner/Adm.[administration family &/or guardian.)				
	(6). See policy on AWOL.						
	(7). Use validation techniques to discuss we resident the emotions behind attempts to leafacility.	ith the ave the					
	(8). Assure res. is provided with ample phy activities.	rsical				:	
	(9). If tolerated place bell on wheel chair of string so whereabouts can be readily determined to the string so whereabouts can be readily determined.	or shoe mined".				:	
,	Review of the care plan indicated that residuated on a "Behavior Management Plan", dated 3/20/02, (nine days after the resident in the NDU). The behaviors listed were a	. It was t was place					

PRINTED: 5/23/

EPARTMENT OF HEA	LTH.	AND HUMAN SERV	ICES			FORM	1 APPROVE 2567
		ADMINISTRATION (X1) PROVIDER SUPPLIER IDENTIFICATION NUM	//CLIA	A. BUILDING	CONSTRUCTION	(X3) DATE S COMPLE	C
	465124			B. WING		5/	10/02
- ALVEST OR SLIPPI	1ER		STREET ADDR	ESS, CITY, STATE	, ZIP CODE		
ME OF PROVIDER OR SUPPL	JILIN		125 SOUTH	900 WEST E CITY, UT 84	1104		
IIDTOWN MANOR			<u></u>		PROVIDER'S PLAN OF CO	RRECTION	(X5)
(X4) ID (CACU DEE	ICIENCY	ATEMENT OF DEFICIENCIE MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	(FULL :	ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	COMPLETE DATE
noted to revol go home. The and there was toward peers their cigarette the data colle physical and AWOL from &/or searchir The care plan no mention of limited the re facility and a this may have resident's en	and ve ve arouse behave a histo- when the ss. The ction si verbal the facing for con- and the fresidents any add e promovironomy	rbal abuse. The behave and cigarette issues or viors were directed towork of him directing his hey would not give him applies there had been as abusive behaviors and cility related to wanting	wanting to vard staff, s behaviors m one of cording to m increase in going g to go home ent plan made DU which y about the mifestation on of the	F 280		*	
The care pla placed in the	n was i	not updated when resid	dent 1 was		-		1
RESIDENT	3						! !
diagnoses th	nat incl rder, c	mitted to the facility or ude schizophrenia, alc losed head injury, neu stress disorder.	ohol abuse,				
Review of revealed the	residen e follov	t 3's closed record on : wing:	5/8/02				
1. A physi resident 3 c	cian's c could h	order dated 2/1/02 doct ave LOA privileges w	umented that ith staff only.		••• •		
documente	d unde	dent 3's plan of care, to tr problem 3, that resid previous history and co	ent 3 was an				

impairment".

PRINTED: 5/23/

FORM APPROVE DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING C B. WING 5/10/02 465124 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 125 SOUTH 900 WEST SALT LAKE CITY, UT 84104 MIDTOWN MANOR PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEEDED BY FULL (X4) ID PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG F 280 F 280 . Continued From page 88 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.

Facility ID: UT0053 If continuation sheet 89 of

EPARTN	MENT OF HEALTH	AND HUMAN SERV	ICES			7010	2567
<u>EALTH</u>	CARE FINANCING	ADMINISTRATION		<u> </u>		(X3) DATE S	URVEY
ATEMENT D PLAN OI	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUN		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED . C	
		465124		B. WING		5/	10/02
A CE OF PR	OVIDER OR SUPPLIER		STREET ADDI	RESS, CITY, STAT	E, ZIP CODE		
			125 SOUT	1 900 WEST	,		
IIDTOW	N MANOR		SALT LAK	E CITY, UT 8		_,	
(X4) ID PREFIX TAG	(FACH DEFICIENCY	ATEMENT OF DEFICIENCIE Y MUST BE PRECEEDED BY LSC IDENTIFYING INFORMA	' FULL j	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	COMPLETE DATE
F 280	Continued From page	89		F 280			
	Review of resident 4 revealed the following	s's closed medical recorng:	rd on 5/9/02			·	
	documented residen	ysician's order, dated 1 t 4 was to have LOA p (but not independently)	rivileges				
	2. The resident was admission as an AW	admitted directly to the VOL risk.	ne NDU on				
	documented under t	ent 4's plan of care, und problem 3, that identifi k per previous history a	ed resident 4				
	Monitor residents v [decrease] chances successful in AWC erounds: B. Call po	nis care plan problem in whereabouts frequently of AWOL5. If resion, oL; A. Search the facility blice ASAP; C. Notify	to dent is ty &				
i	the resident had no	ument, from 2/3/02 to 3 o AWOL attempts, but himlessly" in and out of	that resident		: : :		
	A nurses note, date confused and cam	ed 3/1/02 at 9:00 PM, see out frequently in new	stated "Pt.	! 	:		

No documentation could be found in resident 4's

(moved noon today). Couldn't sleep at night, observed anxious/nervous, reoriented about new surroundings.

A nurses noted, dated 3/2/02 at 12:15 PM documented "...no episodes of being AWOL since placed on open

Will continue to monitor".

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 5/23/ FORM APPROVE

EPARTN	MENT OF HEALTH	A DMINISTRATION					2567
		ADMINISTRATION		(NO) 1 (11 TYP) 1	CONSTRUCTION	(X3) DATE S	
ATEMENT (OF DEFICIENCIES CORRECTION	(XI) PROVIDER/SUPPLIER/ IDENTIFICATION NUM	CLIA IBER:	(X2) MULTIPLE CONSTRUCTION		COMPLETED	
D PLAN OF	CONNECTION			A. BUILDING B. WING			C
		465124		1		5/	10/02
NE OF PR	OVIDER OR SUPPLIER			RESS, CITY, STAT	E, ZIP CODE		
			125 SOUTH	1 900 WEST	24104		
IIDTOW	N MANOR		SALT LAK	E CITY, UT 8		DECTION.	· · · · · · · · · · · · · · · · · · ·
(X4) ID PREFIX TAG	CACU DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
		00		F 280			•
F 280	Continued From page	90 an assessment had been	made by	1 200			
	medical record that	why resident 4 was place	ed on the				1
ļ	the ID I indicating v	as no physician's order	found				<u> </u>
	open unit. There we	resident 4 to the open u	nit and				
	resident 4's care pla	n had not been updated	to reflect				
	any new changes.	_		į			!
	The nurses docume on 3/2/02, 3/3/02, 3	nted AWOL attempts b 3/8/02, 3/10/02.	y resident 4	:			
ė.	0-2/12/02 at 7:25	PM, a nurses note docu	imented				
	"CNA reported pt.	is not in his room, search	ch made of	:			!
	facility unable to b	ocate pt. in building. U	nable to	!			į.
	locate pt outside of	bldg. [building] or sun	rounding	:			
	areaCall placed to	o [police]".		į			•
			idant A was				!
	At 8:45 PM the nu	rse documented that res and the police were not	ified.	1			i
	found in the NDU	and the ponce were not					
	A nurses note date	ed 3/15/02 at 8:00 PM,	documented				
	"Pt alert et land)	confused ongoing. Is re	sting in bed				
	at New Directions	Unit".					!
				!			
	No documentation	could be found in resid	dent 4's				į
		at an assessment had be-	en done by		! ;		
	he IDT indicating	why resident 4 was pla	aced back on	1	:		
	the NDU. There	was no physician's orde	F 10und NDH and	!		•	1
	indicating to move	e resident 4 back to the	ed to reflect				
	resident 4's care p	olan had not been update	A to terrent				
	any new changes.						
	S A rouless of re	sident 4's Care Plan Co	nference				
Í	Summaries dated	2/2/02, 2/11/02, 2/28/0	12 and 3/28/0.	2 !			
	all document that	resident 4 was an "AW	OL risk and		:		1
	continues to spen	d time on NDU".		-	:		į
1	COMMISSION OF The	•					· i

resident 4's plan of care.

6. The facility IDT did not reassess resident 4 when moving him to and from the NDU and did not revise

EPARTN	MENT OF HEALTH	AND HUMAN SERVICE ADMINISTRATION				2567_
ATEMENT	EALTH CARE FINANCING ADMINISTRATION ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (XI) PROVIDER/SUPPLIE IDENTIFICATION NU		1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 5/10/02	
		465124	CITY STA	TE ZID CODE	31	10/02
AME OF PR	OVIDER OR SUPPLIER	Ĭ	REET ADDRESS, CITY, STA	TE, ZIF CODE		
IIDTOW	N MANOR	1: S.	25 SOUTH 900 WEST ALT LAKE CITY, UT			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FUL SC IDENTIFYING INFORMATION	ID L PREFIX N) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH) (E	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETE DATE
F 280	Continued From page RESIDENT 7	91	F 280			•
	facility on 3/1/02 wi	year old male admitted to th diagnoses that included. 's type with behaviors, Squ etes mellitus, hypertension	, lamous			
	On 5/14/02, review 7 revealed the follow	of the medical record for r wing documentation:	esident			
	documented, "Re[secondary to] was endangering self. F	progress note dated 3/1/0 sident admitted to the NDI andering and at risk for desident is court ent is confused with period to discuss past at timeN	U room			
	Detention Pending papers, dated 3/1/0 "Patient is deme in Salt Lake City a Patient has no insignal and danger to him.		on" ng: ng home ays later. Mentally			
	7's facility file, dat 7] is a flight risk. time yesterday afte appointmentha	spital records, maintained ed 3/1/02 documented, ". He had gone AWOL time or [cancer treatment center is been a wanderer for to be elopement risk. He rended care facility] and end	[resident two. Last] an away			

4. The nursing notes, dated 3/2/02, revealed the

following documentation:

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 5/23/ FORM APPROVE 2567

D 23	TANK TO THOUSE A TRANSPORT		2507
HEALTH CARE FINANCING	ADMINISTRATION		
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/C	LIA (X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN OF CORRECTION	IDENTIFICATION NUMB	BER: A. BUILDING	С
	465124	B. WING	5/10/02
		TE ZID CODE	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE	

AME OF PROVIDER OR SUPPLIER		125 SOUTH 900 WEST SALT LAKE CITY, UT 84104				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FI REGULATORY OR LSC IDENTIFYING INFORMATI	ID ULL PREFIX ION) 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 92 "0745 [7:45 AM] resident became very very threatening toward staff attempted to give need medication] unable to give [at] this took up to NDU accompanied by orderlie "0755 [7:55 AM] NDU [residents and state back upstairs [and] noticed that resident was to searched around the facility [and] up		came not in the				
	the block police notified [administrator] notified resident taking off ss [social service] notified "1100 [11:00 AM] [hospital] called [and] stathey had [resident 7] [and] that they would be him back"	d."				
	5. In an interview, on 5/14/02 at 1:00 PM, facility social service staff member, she stat resident 7 was admitted to the facility due to medical needs and wandering behavior. She that resident 7 attempted to go AWOL sever and in fact had gone AWOL one time. She he was sent back to the hospital on 3/13/02 increased behaviors and attempts to tear do fence on the secure unit.	ed that o his e stated ral times stated that due to his				
	A nursing note, dated 3/5/02, documented, aide] reported to unit that pt [resident 7] at climb up and over fence of the alzheimer's [at] that time"	tempted to				
	A nursing note, dated 3/13/02, documented Attempting AWOL – trying to tear down to the courtyard of the NDU – threatening photo staffMD notified [and] new order not transport ptto [name of hospital]"	he tence in ysical harm				
	6. Review of resident 7's comprehensive prevealed documentation that resident 7 was allowed to leave the facility with staff or f	is only				

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE

CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

 \mathbf{C} 5/10/02

(X5)

COMPLETE

DATE

465124

B. WING STREET ADDRESS, CITY, STATE, ZIP CODE

PREFIX

125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

MIDTOWN MANOR

(EACH DEFICIENCY MUST BE PRECEEDED BY FULL (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX TAG F 280 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.

SUMMARY STATEMENT OF DEFICIENCIES

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 lDTmeetings.

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 490 483.75 ADMINISTRATION

SS=K

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

Facility 1D: UT0053 If continuation sheet 94 of

FORM APPROVE DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C B. WING 5/10/02 465124 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 125 SOUTH 900 WEST MIDTOWN MANOR SALT LAKE CITY, UT 84104 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES 1D (X5) (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFLX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 490 F 490 | Continued From page 94 investigating and addressing incidents of neglect, F-490 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 The Administrator will follow up on the ensure that residents were provided the opportunity to above plan of correction to insure that it is attain or maintain their highest practicable well-being accomplished as an ongoing part of the and safety. This had the potential to effect all operation of the facility. The follow up will residents in the facility. also include a review of the policy and procedures of the facility with new and Findings Include: current employee training. The employees On 5/7/02, an abbreviated survey was initiated. On will also be tested with spot checks that 5/10/02, the facility administration was noticed of the they not only were trained, but that they elements of Immediate Jeopardy to resident health and 6/8/02 understand what their individual safety and Sub-Standard Quality of Care. The responsibility is in specific situations in determination of Immediate Jeopardy was based on regard to that training. The facility will be findings of significant non-compliance in the areas of Abuse Prohibition [42 Code of Federal Regulations operated in a manner that does not (CFR) 483.13(a)(c)1(i) and (2), Tags F-221, 224, tolerate nor allow resident neglect or abuse F225, and F-226] and Administration/Quality in any form. Assessment and Assurance [42 CFR 483.75(o) Tag F-490 and 521]. The Quality Assurance Committee will provide over-site of the administrator. The Failure of the facility to address problems identified in these areas were present to such an extent that committee will be free of any penalty from residents were residing in an environment in which the the administration for discussing or potential for resident harm was likely to occur. pointing out deficiencies per the chain of command. The Administrator will not 1. Facility administration failed to have systems in prohibit nor penalize any member of the place that would ensure that residents were provided committee from contacting the State if with services to protect them from restraint via seclusion in the NDU (New Dimensions Unit) imposed remedies for non complinance of any state for purposes of discipline or convenience, and not regulations listed in this plan of correction required to treat the resident's symptoms. (Refer to Tag or any other area covered by the Quality F-221). Assurance Committee are not pursued and achieved.

2. The facility did not assess, care plan and monitor residents with AWOL (absent without leave) behaviors

PRINTED: 5/23/ FORM APPROVE 2567

AND PLAN OF CORRECTION IDENTIFICATION M		(XI) PROVIDER/SUPPLIER IDENTIFICATION NUN		(X2) MULTI A. BUILDING B. WING	PLE CONSTRUCTION	(X3) DATE COMPL	ETED C			
		465124	STREET ADDR	<u> </u>	ATE ZID CODE		/10/02			
	OVIDER OR SUPPLIER N MANOR		125 SOUTH SALT LAKE	900 WEST	,					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			(EACH DEFICIENCY MUST BE PRECEEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE NCY)	(X5) COMPLETE DATE
F 490	provide goods and sophysical harm, ment Residents who were allowed to leave the them to harm. (Refe 3. The facility failed incidents of abuse of AWOL residents, not the results of their in Agency and to other law through establist F-225) 4. The facility failed written policies and or neglect from AW the NDU. (Refer to 3. The facility's Quito address incidents and to monitor and	et. Neglect is defined as ervices necessary to averal anguish, or mental illogaritively impaired we facility unsupervised eer to Tag F-224) d to thoroughly investigate neglect regarding missor did they report the investigations to the State officials in accordance shed procedures. (Reference to develop and implessor procedures that prohib/OL and restraint via se	s failure to bid iness. ere exposing eate sing or cidents or e Survey e with state r to Tag ement ited abuse clusion in ocess failed chaviors, criteria for	F 490	Annthly week monthly X 3 quarterly I these defice discussed th	will be cly x + mo. then of ssues region we have we will be with the world with the wear to be a sue of the wear to be a sue o	meld Then least arding			
F 521 SS=K	The quality assessments at least quart to which quality as are necessary; and appropriate plans of quality deficiencies. A State or the Secrethe records of such disclosure is relate	and assurance completely to identify issues we sessment and assurance develops and implement of action to correct identify. The tary may not require determined action to complete except inso do to the compliance of the requirements of this set acquirements of this set.	vith respect activities ats tified disclosure of far as such such	F 521						
CMS-25671		ATG112000 Event i	10Y111	Facility ID:	UT0053	If cont	nuation sheet 96 of			

(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING \mathbf{C} B. WING 5/10/02 465124 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **125 SOUTH 900 WEST** SALT LAKE CITY, UT 84104 MIDTOWN MANOR PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE 1D SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG F 521 Continued From page 96 F 521 F-521 This REQUIREMENT is not met as evidenced by: Based on a review of the facilities Quality Assurance The Quality Assurance Committee will meet meeting minutes, facility monitoring systems, and and review the policy and procedures interviews with the facility Administrator, and the reflected in this plan of correction. The Director of Nurses, it was determined that the facility's committee will meet at least quarterly for quality assessment and assurance activities did not this purpose. An agenda will be made that develop and implement appropriate plans of action to correct identified quality deficiencies in the areas of specifically includes: residents' AWOL (absent without leave) behaviors, 6/8/02 possible neglect of residents and the appropriate Reporting and review of prior Quality placement and maintenance of residents in the New Assurance Meeings. Including any follow Dimensions Unit (NDU). up items that were recommened and Findings include: accomplished. 1. An interview was conducted with the facility A report that the facility is following this Administrator on 5/13/02 at 1:00 PM, concerning the plan of correction. This will include that quality assurance process. He stated the department documentation, review, training, and heads would bring their concerns to the quality updates for each deficiency is followed as assurance (QA) meetings. The meetings had been held stated in the plan of correction. quarterly however recently they had changed the frequency to monthly. Monitoring of issues was assigned to the department heads. Suggestions for implovements and effectiveness of the overall operation of the The social service representative was also interviewed facility. on 5/13/02, about the quality assurance process. She indicated they have met quarterly with the physician Notice to the committee of any residents and pharmacist in attendance. They review concerns that require or may require special Plans of brought by staff, residents, and families. Identified problems were assigned to department managers who Care, Assessments, and/or Behavior investigate and review findings in the next meeting. Management Plans. 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 If continuation sheet 97 of Facility ID: UT0053 Fvent l

PRINTED: 5/23/ FORM APPROVE

6/8/02

TATEMENT OF	DEFICIENCIES
NTO DE AN OF C	

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

465124

(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING

(X3) DATE SURVEY COMPLETED C

5/10/02

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

125 SOUTH 900 WEST SALT LAKE CITY, UT 84104

MIDTOWN MANOR

PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE PREFUX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG F 521

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)

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 porticipate in weekly IDT meeting every week x 7 month then monthly week x 7 month theast quarterly.

CARE FINANCING	ADMINISTRATION _					2567
PLAN OF CORRECTION IDENTIFICATION NUMBER		CLIA BER:	(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION	COMPLE	
OVIDED OF CLIPPI IED		STREET ADDRE	SS. CITY, STA	TE. ZIP CODE		0102
NAME OF TRO SEE ON SEE SEE			900 WEST			
(EACH DEFICIENC	Y MUST BE PRECEEDED BY F		ID PREFIX TAG	(EACH CORRECTIVE ACTION)	SHOULD BE	(X5) COMPLETE DATE
Continued From page	98		F 521			!
		; !	•			1
 		!				·
	•	:	:			
1			:			
:						
;						
į	ı					
1						
	·					
		!	;			
		i				
: · · · · · · · · · · · · · · · · · · ·						
· · · · · · · · · · · · · · · · · · ·						
	OF DEFICIENCIES F CORRECTION OVIDER OR SUPPLIER IN MANOR SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY REGULATORY OR LSC IDENTIFYING INFORMAT Continued From page 98	OF DEFICIENCIES F CORRECTION (XI) PROVIDERSUPPLIER: 465124 OVIDER OR SUPPLIER IN MANOR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 98	OF DEFICIENCIES F CORRECTION (X1) PROVIDER SUPPLIER (A65124 (A65124 (A72) MULTIPIT A. BUILDING B. WING (A73) MANOR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 98 F 521	OF DEFICIENCY (X1) PROVIDER SUPPLIER OVIDER OR SUPPLIER OVIDER OR SUPPLIER IN MANOR STREET ADDRESS. CITY, STATE, ZIP CODE 125 SOUTH 900 WEST SALT LAKE CITY, UT 84104 SECULATORY OR ISC IDENTIFYING DIFORMATION) Continued From page 98 F 521	OF DEFICIENCIES F CORRECTION (X1) PROVIDERS SUPPLIER 465124 OVIDER OR SUPPLIER IN MANOR STREET ADDRESS, CITY, STATE, ZIP CODE 125 SOUTH 990 WEST SALT LAKE CITY, UT 84104 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 98 F 521