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

PRINTED: 08/02/2005
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING ____ B. WING ____	07/20/2005

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

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F 156 SS=B	483.10(B)(5) - (10) NOTICE OF RIGHTS AND SERVICES The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes a description of the manner of protecting personal funds, under paragraph (c) of this section. A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid	F 156 8/15/05 acceptable completion date 9/5/05 Baumbach RN	The facility has included a Determination of Admission Form that will be part of each admission procedure. This procedure was put in place at the time of survey. The Administrator has inserviced the Admission and social service personnel of the requirement to review with each resident at the time of admission why Medicare will, or will not, cover the cost of the stay. The resident will also receive information regarding the right to request a demand bill. The Administrator will monitor that this procedure is followed during each admission. This procedure will also be reviewed not less than quarterly by the Quality Assurance Committee. Utah Department of Health HD2666076 AUG 11 2005 Bureau of Health Facility Licensing, Certification and Resident Assessment	8/10/05

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: John N Cappadonia | TITLE: Administrator | (X6) DATE: 8-11-05

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 156	Continued From page 1 eligibility levels. The facility must comply with the requirements specified in subpart I of part 489 of this chapter relating to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on record review and an interview with the facility social service worker, it was determined that the facility was not informing residents on admission why specific services may not be covered under Medicare. The facility also did not inform the residents of their right to request that the facility submit a bill to the Medicare payor for review (demand bill). Findings include:	F 156		

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F 156	Continued From page 2 On 7/19/05, a review of 5 resident admission records was completed. All five residents were admitted under a payor source other than Medicare. There was no evidence in the records that the facility had informed the residents why the services they were to receive in the facility were not covered under Medicare. There also was no evidence that the facility had informed the residents of their right to request a demand bill. An interview was held with the facility social service worker on 7/19/05 at 9:00 AM. The social worker stated that she was not aware that residents were to be informed on admission why Medicare was not going to cover the stay or that they had the right to request a demand bill.	F 156		
F 246 SS=E	483.15(e)(1) QUALITY OF LIFE A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, a confidential resident group interview, and interview with the facility administrator, it was determined that the facility was not providing reasonable accommodations for residents to be toileted. Specifically, there are no bathroom facilities available for residents to use in the basement of the building where the dining room is located.	F 246	The facility will improve the bath-Room facilities near the dinning area to meet the requirements of state licensure.	9/5/05

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F 246	Continued From page 3 Findings include: The facility dining room and activities room are located in the basement of the facility. The residents access the basement by use of an elevator, and those that are able use a flight of stairs. On 7/20/05 at 11:30 AM, a confidential group interview was held with 8 alert and oriented facility residents. Seven of the eight residents used wheelchairs for mobility. As part of the interview, the residents were asked questions about the building, which included their bedrooms, dining room and activities room. Six of the eight residents stated that there were no bathrooms accessible to the residents in the basement. The six residents used wheelchairs for mobility. The residents stated that there were bathrooms down in the basement that they were able to use previous to the 2004 annual certification survey, but the administrator had closed them and they could not longer use them. The residents stated that when they were in the dining room during meals or in the activity room, they had to return upstairs to use the bathroom. The residents stated that if they have to leave during a meal to return upstairs to use the bathroom, when they return sometimes their meal has been removed. Three of the six residents stated that they have had incidents of incontinence due to inaccessibility of a bathroom in the basement. An interview was held with the facility administrator on 7/20/05. The administrator stated that he had closed the restrooms because	F 246	The maintenance staff will complete The necessary repairs to meet these standards. This will include installing the required alarm system for any problems which may arise while utilizing the bathrooms. The Administrator will monitor the completion of this project. The Quality Assurance Committee Will review the project at the Quarterly Committee meeting.	9/5/05

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F 246	Continued From page 4 the facility had been sited during the 2004 annual certification survey for not having a communication system in those bathrooms. The administrator stated he had chosen to discontinue the use of those restrooms instead of installing the communication system.	F 246		
F 325 SS=G	483.25(i)(1) QUALITY OF CARE Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. This REQUIREMENT is not met as evidenced by: Based on interview, observation and record review, it was determined the facility did not ensure the resident maintained acceptable parameters of nutritional status, including weight and protein levels, for 1 of 15 sample residents. Specifically, resident 2 did not receive the nutational support the facility had identified he should have. (Resident 2) Findings include: Resident 2 was a 75 year old male who was admitted to the facility July 1999 with diagnoses including alcoholic dementia, pancreatitis and intermittent explosive disorder. On 7/19/05 at 8:10 AM, resident 2 was observed during breakfast. Resident 2 sat alone, within line-of-sight of the restorative nurse aide (RNA). Resident 2 sat erect with his hands in his lap and	F 325	Resident 2 is now part of the Restorative feeding program. The RNA will work with the resident in the dinning room during breakfast and lunch. Resident 2 will be up in a wheel chair in room during the 10 am and 3 pm snack. During snack times, the RNA will encourage dietary intake and assist when and if necessary. The nursing assistant will assist and feed Resident 2 as necessary during dinner and HS snack. The intake for the six (6) meals offered daily will be recorded in the nursing aide flow sheets.	8/11/05

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F 325	Continued From page 5 watched the other people in the dining room. Resident 2 took an occasional bite of food then put his hands back in his lap. With the RNA's cues, resident 2 drank three glasses of thickened liquids. On 7/19/05 at 10:00 AM, resident 2 was observed to be sitting in his wheelchair in his room. During continuous observation from 10:00 AM until resident 2 was taken to the dining room at 12:15 PM, no one was observed to enter resident 2's room with a snack. On 7/19/05, resident 2 was observed during lunch. Resident 2 sat alone, within line-of-sight of the RNA. When he was cued by the RNA or other nursing assistant, resident 2 picked up a glass and drank. The nursing assistants offered bites of food to resident 2, and then walked away. Resident 2 did not attempt to eat independently, but accepted bites of food as they were offered by the RNA or other nursing assistant. At 1:20 PM, resident 2 was assisted to bed, where he remained until he was taken to the dining room for supper at 5:00 PM. On 7/19/05, resident 2 was not observed to be offered snacks or small meals between his meals. On 7/20/05, resident 2 was observed during breakfast. Resident 2 sat alone within line-of-sight of the RNA. Resident 2, who had survived attempted poisoning in the past, voiced concern that his food had been poisoned. The RNA effectively reassured him that the food was safe and the resident accepted a bite of food from the RNA. Resident 2 was observed to feed himself his meal slowly with occasional assistance of nursing assistants. The resident	F 325	The Director of Nursing will monitor the flow sheets weekly to assure they are completed. Members of the Quality Assurance committee will monitor employees during daily rounds to review and ensure that the staff are offering and assisting Resident 2 as necessary. Weekly dietary meetings will be held with the Registered Dietitian, Director of Nursing, Dietary manager and charge nurses. The purpose of this meeting will be to insure that all dietary recommendations are reviewed and that diet slips and telephone orders are correctly reflected on the diet tray card. This will insure that diet orders and recommendations are followed and incorporated into each resident's plan of care. This procedure will be monitored by the Director of Nursing.	8/11/05

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F 325	Continued From page 6 ate most of his breakfast, except his toast. Resident 2 drank all of his thickened liquids independently when cued. On 7/20/05 at 8:30 AM, resident 2 was observed to be taken to his room from the dining room. At 8:45 AM, resident 2 was assisted into bed, where he laid uninterrupted, until 11:25 AM. Resident 2 was observed to be in his bed at 3:10 PM when afternoon snacks were being passed. The nursing assistant did not enter resident 2's room to offer the resident a snack. Resident 2 was not observed to be offered snacks or small meals between his meals. On 7/19/05 at 8:50 AM, the RNA was interviewed. The RNA stated she had previously worked with resident 2 for restorative dining and that she continued to watch him and cue him to eat and drink. The RNA stated that resident 2 had a poor appetite. The RNA stated that resident 2 did not like many foods and was sometimes suspicious of being poisoned. She stated the resident liked cheese and bananas and pasta. She stated that resident 2 would eat two or three servings of food when pasta was served. On 7/20/05 at 3:40 PM, the RNA was interviewed. The RNA stated that snacks were not offered to resident 2. The RNA stated that resident 2 needed his rest to help prevent aggressive behaviors so he was assisted to bed between meals. The RNA stated that resident 2 was a very picky eater and that he had to be reassured, at times, that his food was safe to eat. She stated, further, that if resident 2 refused to eat his meal, they	F 325	This procedure will be reviewed by the Quality Assurance Committee not less than Quarterly. Any proposed improvements to the procedure will be discussed and implemented if deemed to improve the procedure.	8/11/05

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F 325	Continued From page 7	F 325		

would give him a boiled egg, a banana or cheese. The RNA stated that a banana and cheese "will always work". The RNA repeated, "Always." The RNA stated that resident 2 loved to eat pie and fruit crisp, and he loved Italian foods such as pasta and pizza.

On 7/20/05 a 9:00 AM, a telephone interview was conducted with resident 2's family member. The family member stated she had been concerned to learn that resident 2 had experienced a significant weight loss. The family member stated that she was concerned the facility had not accommodated resident 2's diet to his medical condition. The family member stated that resident 2 should not have milk and should have been receiving 6 small meals per day because of his history of stomach and bowel problems. The family member stated that resident 2 had a number of gastrointestinal disorders, including part of the resident's stomach had been removed more than 10 years previously.

The family member stated that in November or December 2004, she explained resident 2's dietary needs to the registered dietician consultant. The family member stated that, due to his medical history, resident 2's surgeon had advised the resident to eat six small meals each day. The family member stated that, at that time, the facility had agreed to change resident 2's diet to six small meals each day.

On 7/20/05 at 11:25 AM, the facility's Registered Dietician (RD) consultant was interviewed. The RD stated that during the conversation with resident 2's family member, on 12/2/04, it had been agreed that resident 2 would receive six small meals daily. The RD stated that, since

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F 325	Continued From page 8 resident 2 had been put on Hospice care, she thought Hospice was managing the resident's diet. Resident 2's medical record was reviewed on 7/19/05. Resident 2's Nutritional Risk Review, dated 3/10/05, was signed by dietary and by the RD. The Nutritional Risk Review revealed resident 2's diet included 6 small meals per day. The risk review revealed resident 2, at 73 inches tall and 127.5 pounds, was 77% of his ideal body weight and that the resident had experience an 8.9% weight loss over 3 months and a 17% weight loss over 6 months. Resident 2 was given a terminal diagnosis of arteriosclerotic dementia and referred for Hospice care, 1/6/05. On 7/8/05, the physician changed the resident's Hospice diagnosis to debility. On 1/22/05, the RD for Hospice, performed the initial nutritional assessment for resident 2. The Hospice RD documented that resident 2 had lost 38 pounds (22% of his body weight) during the previous year, from 172 pounds January 2004 to 134 pounds January 2005. The Hospice RD documented that resident 2 was at 72.8% of his ideal body weight January 2005. The Hospice RD documented that the facility had implemented interventions to deal with resident 2's nutritional issues of weight loss. The RD documented that the facility's interventions included that resident 2 was to be provided with 6 small meals daily, Mighty Shakes at 3 meals and supplements with medication passes. The Hospice RD documented that there was no	F 325		

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F 325	Continued From page 9 recommendation to alter the facility's plan for resident 2's diet. The quarterly Minimum Data Set (MDS) assessments dated 6/9/05, revealed resident 2 weighed 121 pounds. The comprehensive MDS assessment, dated 3/17/05, revealed resident 2 weighed 122 pounds and had experienced a significant weight loss. The quarterly MDS assessment, dated 12/23/04 revealed resident 2 weighed 140 pounds and had experienced a significant weight loss of 9% over the previous 3 months. Resident 2's quarterly MDS assessments, revealed the resident weighed 154 pounds 9/30/04, and 161 pounds 7/8/04. Resident 2's quarterly Minimum Data Set (MDS) assessments revealed the resident had weighed 161 pounds 7/8/04 and 154 pounds 9/30/04. The quarterly MDS assessment, dated 12/23/04, revealed resident 2 weighed 140 pounds and had experienced a significant weight. The comprehensive MDS assessment, dated 3/17/05, revealed resident 2 weighed 122 pounds and had experienced a significant weight loss. The quarterly MDS assessment, dated 6/9/05, revealed the resident weighed 121 pounds. On 7/20/05 the facility documented resident 2's weight sheet that the resident weighed 119.5 pounds. Laboratory results dated 1/3/05 revealed resident 2's albumin was 2.5 g/dl and the results dated 6/29/05 revealed the resident's albumin was 2/7 g/dl (grams per deciliter). The laboratory specified the normal reference range was 3.4 to 5.0 g/dl. Resident 2's Nutritional Status Care Plan, last	F 325		

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F 325	Continued From page 10 updated 5/26/05, revealed a concern that the resident was at risk for severe weight loss due to poor nutritional intake and history of weight loss. The facility's goal was that the facility would offer the resident what he wanted to eat and that his foods would be made appealing. The facility planned approaches to help meet the goal by providing his diet as he desired and offering the foods he preferred. A copy of resident 2's Diet Tray Card was obtained from the Dietary Manager. The card revealed that resident 2 was to receive a mechanical soft diet with no added salt and nectar thick liquids. The tray card revealed that resident 2 was on a special nutrition program and was to receive 8 ounces of high protein Mighty Shake and 2 glasses of water plus a glass of juice at every meal. Dietary had no documentation that resident 2 was to receive 6 small meals every day. A "CHANGE OF DIET" directive for resident 2 was documented 12/2/04 by a facility Registered Nurse (RN). The RN documented that resident 2 was to receive 2, 4 ounce Mighty Shakes three times a day with meals, and that he was to receive six small meals every day.	F 325		
F 371 SS=E	483.35(h)(2) DIETARY SERVICES The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation of tray line during two meals, it was determined that the facility did not	F 371	An inservice was given by the Registered Dietitian to the dietary staff which included: The proper procedure for changing gloves when performing duties on the trayline.	8/10/05

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F 371	Continued From page 11 prepare and serve food under sanitary conditions. Findings include: On 7/19/05, a continuous observation was made of the breakfast tray line, in the main dining room, from 7:30 AM to 8:05 AM. The meal consisted of pancakes, bacon, hot cereal and cold cereal and an apple spice ring. The following observations were made: The cook was observed to be wearing gloves. The cook was picking up plates, bowls, serving utensils, and the lids off the steam table with her gloved hands. The cook was observed to pick up a plate and then pick up the pancakes, bacon and a spiced apple ring with her gloved hand a place them on the plate. At one point the cook had to return to the kitchen to obtain a box of plastic wrap. The cook had to unlock the door to the kitchen. The cook then returned to the serving area and continued to serve the meal. Five minutes later the cook was observed to change her gloves. She then continued to serve out the rest of the meal in the same manner. The cook was observed picking up plates, bowls, serving utensils, and the lids off the steam table, then picking up the pancakes, bacon and the spiced apple ring with her gloved hand, and place them on the plates. On 7/20/05, a continuos observation was made of the breakfast tray line, in the main dining room, from 7:30 AM to 7:55 AM. The meal consisted of scrambled eggs, hash browns, toast, cereal and bacon. The cook was observed to be wearing gloves.	F 371	The proper use of serving utensils When performing duties on the trayline. The proper handling of ready-to-eat foods when working on the trayline. The information in this inservice will be reviewed monthly by either the Registered Dietitian or the Dietary Manager as part of the regularly scheduled inservice. Documentation of these inservices will be kept in the dietary inservice manual. The Registered Dietitian will review the inservice documentation on a monthly basis as part of the monthly dietary services inspection and report to the Administrator as part of the monthly exit interview. Any recommendations for follow up or improvements will be addressed. This procedure will be monitored for completion by the Dietary Manager. The Quality Assurance Committee Will review this procedure not less than Quarterly to insure the desired goals are met.	8/10/05

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F 371	Continued From page 12 The cook was picking up plates, bowls, serving utensils, and the lids off the steam table with her gloved hands. The cook was observed to pick up a plate and pick up the toast and bacon with her gloved hand and place them on the plate. The cook was observed to change her gloves once during the meal service. She continued to serve out the rest of the meal using the same technique wearing gloves, picking up the plates, bowls, serving utensils and the lids off the steam table and pick up the toast and bacon with her gloved hand and place them on the plates.	F 371		
F 444 SS=E	483.65(b)(3) INFECTION CONTROL The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observations, it was determined the facility staff did not wash their hands appropriately after each direct resident contact for which handwashing was indicated by accepted professional practice. Findings included: On 7/19/05 from 12:56 PM until 1:10 PM, observations were made of staff washing residents after their lunch meal. Nursing assistant A put a stack of wash cloths in a plastic basin of water which was on a table next to the exit doorway of the main dining room. Nursing assistant B had finished assisting a	F 444	An inservice was held with the Nursing Assistants to instruct them of the proper way to clean the residents after each meal. The Nursing Assistants will wash their hands and replace their gloves before offering a clean wash cloth to the residents that are able to wash their own face and hands. Each resident that needs assistance with cleanup will not be helped until the Nursing Assistant has clean hands and gloved after each resident is cleaned.	8/11/05

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING ______ B. WING ______	07/20/2005

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

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F 444	Continued From page 13 resident to eat. Nursing assistant B pushed the resident to the doorway in the resident's wheelchair and took the resident's soiled clothing protector to put in another container. After touching the resident's wheelchair and soiled clothing protector, nursing assistant B took a wet wash cloth from the pink basin. The nursing assistant held the cloth above the basin and wrung water out of the cloth over the other wash cloths. Although the nursing assistant wore gloves, the water and the other wash cloths in the pink basin had become contaminated. Nursing assistant C took a resident to the doorway next to the pink basin. The nursing assistant did not wear gloves. After touching the handles of the resident's wheelchair, nursing assistant C took the resident's soiled clothing protector. The nursing assistant then picked up a wet wash cloth from the pink basin and wrung it out over the other wash cloths in the basin. Nursing assistant C washed the resident's hands and then the resident's face and helped push the resident's wheelchair out of the dining room. Other residents were beginning to be lined up at the doorway. Without washing his / her hands, nursing assistant C pulled the next resident's wheelchair toward him / her, using the arm rails of the wheelchair. The nursing assistant took the resident's soiled clothing protector and then reached into the pink basin for a new cloth. The nursing assistant was observed to wring water from the new cloth over the others in the basin, and proceeded to wash the resident's hands and face. As residents were taken to the doorway to leave the dining room, other nursing assistants were observed to use cloths from the same pink basin	F 444	One Nursing Assistant will be Given the duty to remove the soiled garment protector. This procedure will be incorporated into the ongoing inservice training of the Nursing Assistants to insure that this procedure is followed in the future. The Director of Nursing will monitor that the training is accomplished and followed. The Quality Assurance Committee will review this procedure at least quarterly.	8/11/05

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F 444	Continued From page 14 to wash the residents' hands and faces. A new wash cloth was used for each resident, but each cloth had been laying in the pink basin with contaminated water and was wrung out over the remaining wash cloths, further contaminating the water in the basin. By 1:04 PM, nursing assistant A was observed to stand at the doorway, washing residents' hands and faces as they left the dining room. The nursing assistant was observed to wash three or four residents with wet cloths from the contaminated water before leaving to wash his / her own hands, which had also become contaminated. Whenever nursing assistant A was not at the doorway, other nursing assistants washed the residents as they were assisted out of the dining room. Each nursing assistant used the same procedure to wring out the wet cloths. After the first wash cloth was wrung out over the other cloths in the pink basin, every nursing assistant's hands or gloves were contaminated by the increasingly soiled water before they washed the next resident's face and hands. On 7/20/05 observation was made in the dining room during the breakfast meal. Wash cloths were stacked in a pink plastic basin of water which had been placed on a table by the exit doorway. The nursing assistants were observed to take a new cloth for each resident they washed. Each nursing assistant was observed to wring the wash cloths out over the other cloths in the basin. Although the nursing assistants wore gloves as they assisted the residents with their meals, most	F 444		

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

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F 444	Continued From page 15 did not wash their hands or change their gloves before washing the residents' hands and faces. After the first wash cloth was wrung out over the other cloths in the pink basin, every nursing assistant who used the basin had contaminated their hands or gloves in the increasingly soiled water before they washed the next resident's face and hands. Nursing assistant D was observed to stand at the doorway as most residents were leaving the dining room. Nursing assistant D was observed to wash the hands and faces of four residents before leaving to wash his / her hands.	F 444		