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

PRINTED: 11/02/2006
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 ______	10/26/2006

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226 SS=E	483.13(c) STAFF TREATMENT OF RESIDENTS	F 226		

F 226 — 483.13(c) STAFF TREATMENT OF RESIDENTS (SS=E)

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

This REQUIREMENT is not met as evidenced by:

Based on staff interviews, review of employee files and a review of the facility's policies and procedures on abuse, it was determined that the facility did not implement procedures that included an investigation for a history of abuse, neglect or mistreating residents prior to allowing nurse aide staff to provide direct care to residents. The facility did not obtain Certified Nurse Aide (CNA) Registry verification for 4 of 4 CNA and 1 of 1 nurse aides (NA) reviewed. Staff identifiers: NA 1, CNA 1, CNA 2, CNA 3, and CNA 4.

Findings include:

On 10/25/06, a list of current, new employees was obtained and their files were reviewed to determine the date the facility obtained CNA Registry verification and also the date in which the employee began providing direct care to residents.

CNA 1 began providing direct care to residents on 6/22/06. Per documentation, the facility did not obtain CNA Registry verification until 7/31/06

CNA 2 began providing direct care to residents on 7/7/06. Per documentation, the facility did not obtain CNA Registry verification until 7/13/06

11/15/06 POC acceptable Completion date 11/24/06

Provider's Plan of Correction (F 226):

The facility has completed Nursing Aide Registry verifications on NA 1, CNA 1, CAN 2, CNA3, and CAN 4, and all hired nursing assistants. The verification will be completed on all new hires prior to them providing direct patient care to any resident(s).

The Personnel Director will monitor that this procedure occurs to insure that a Nursing Aide Registry verification is completed for new hires prior to them working or providing any direct patient care. The new hire log will be expanded to include a check for:

1 - Hire Date
2 – CNA Registry Check
3 – First Day Worked

A new employee will not be allowed to begin work on any day prior to the date of the CNA registry check. This log and procedure will be reviewed by the Personnel Director not less than monthly to insure that this procedure is followed, and the requirement is met.

The quality assurance committee will review this process not less than quarterly to insure that this occurs on an on-going basis.

Completion date: 11-8-06

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: ADMINISTRATOR/OWNER (X6) DATE: 11-15-06

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 226	Continued From page 1 CNA 3 began providing direct care to residents on 6/30/06. Per documentation, the facility did not obtain CNA Registry verification until 7/7/06. CNA 4 began providing direct care to residents on 8/4/06. Per documentation, the facility did not obtain CNA Registry verification until 8/7/06. NA 1 began providing direct care to residents on 6/14/06. Per documentation, the facility did not obtain CNA Registry verification until 6/15/06. An interview was held with the Assistant Administrator and the Human Resource Director on 10/25/06 at 1:35 PM. The Assistant Administrator stated that he had been the individual in the facility that completed the CNA Registry verification and that he has been doing it when the employee's first payroll check was made.	F 226	NOTE: A correction should be noted regarding the information in the last paragraph of the SUMMARY STATEMENT OF DEFICIENCIES. (Page 2 of 13) The Assistant Administrator stated that the CNA registry check was completed when the employee information was entered in the payroll program, not at the time the first payroll check was made. Most times new hire information is entered in the payroll program on the first day a new worker begins. However, as stated in the above answer, registry checks will now be done <u>before</u> any new hires perform any direct patient care.	

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F 278 SS=B	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility did not complete accurate Minimum Data Set (MDS) assessments for 3 of 15 sample residents. Residents 1, 6, and 9. Findings included:	F 278	The medical records consultant will work with the Director of Nursing to assure that the MDS is accurate for residents 1, 6, and 9, and that the MDS reflects the correct status of that resident. The medical record consultant will work with the Director of Nursing on conducting and coordinating each assessment with the appropriate participation of other health professionals in a timely manner using the proper look back period. A significant correction was completed to reflect the days and minutes in resident 1's medical record. [redacted] Rehabilitation will be responsible for reviewing and checking all documentation used on section P1-b of the MDS before the input is done and after the information has been verified for accuracy. A significant correction was completed for resident 9 at the time of survey. The Dietary Supervisor will be responsible for reviewing the documentation used on sec K1-6 before computer input is done and after the information has been verified for accuracy.	11-24-06

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F 278	Continued From page 3 1. Resident 6 was admitted to the facility 11/29/03 with diagnoses that included cellulitis, hypertension and neurotic depression. A comprehensive significant change MDS assessment, dated 8/24/06, had been complete for resident 6. The resident assessment protocol (RAP) summary referred to readmission notes dated 7/24/06 for additional assessment information regarding areas of care triggered by the MDS. The readmission notes were completed four weeks prior to the MDS assessment reference date. 2. Resident 1 was admitted to the facility on 8/31/06 with diagnoses that included chronic pancreatitis, venous insufficiency, joint contractures of forearm, pelvis, and neck, depression disorder and prolonged post traumatic stress disorder. Resident 1's medical record was reviewed on 10/23/06. On 9/13/06, the facility's inter-disciplinary team completed an admission MDS assessment for resident 1. Under Section P of the MDS, Special Treatments and Procedures, resident 1 was assessed as having received physical therapy five of the previous seven days. The total amount of time resident 1 was assessed as having received physical therapy was 175 minutes. A review of the therapy section of resident 1's medical record on 10/23/06 revealed no documentation that resident 1 had received physical therapy. In the morning of 10/24/06, resident 1's medical record was again reviewed. Within the therapy section of the medical record	F 278	The Assistant Director of Nursing will monitor this procedure by having Nursing, Social Services, Dietary and special treatments, all review these minimum Data Sets for accuracy of information on a weekly basis, before and after the data entry has been accomplished. The assistant Director of Nursing will review the RAP Assessment information weekly during the IDT meeting to insure each residents nature of condition, complication and risk factors, and any additional factors that need to be considered, including any need for further evaluation is addressed using the proper look back period. This review will occur on a weekly basis. The quality Assurance Committee will review this procedure on a quarterly basis to insure that this requirement is met on an on-going basis.	

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F 278	Continued From page 4	F 278		

was a Physical Therapy Progress Summary. This summary was for the period of 9/7/06 to 9/13/06. The physical therapist documented that resident 1 was seen for therapy on 9/7/06 for an estimated time of 30 minutes, and on 9/8/06 for an estimated time of 45 minutes. The physical therapist documented that resident 1 refused therapy on 9/11/06. On the bottom of this form, the physical therapist documented, " D/C (discharge) from PT (physical therapy) services per pt (patient) request. "

Per documentation available in resident 1's medical record, resident 1 received physical therapy two days, 9/7/06 and 9/8/06, for a total of 75 minutes.

3. Resident 9 was admitted on 9/12/06 with diagnoses that included paraplegia, pressure ulcer, osteomyelitis, hypertension, and spinal abscess.

Resident 9's medical record was reviewed on 10/23/06.

Resident 9's admission MDS, dated 9/25/06, documented under section K. Oral/Nutritional Status that resident 9's weight was 160 pounds (lbs.). The admission nurses notes, dated 9/25/06 documented resident 9's weight was 145 lbs..

In an interview with the Director of Nursing (DON) she said resident 9 weighed 145 lbs. on admission and the weight on the MDS was wrong.

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F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review it was determined, that the facility did not ensure that 2 of 15 sample residents received the care and services to maintain the highest practicable physical well being. Resident identifier 1 and 9. Findings include: 1. Resident 9 was admitted on 9/12/06 with diagnoses that included paraplegia, pressure ulcer, osteomyelitis, hypertension, and spinal abscess. Upon admission, resident 9 had a Stage II pressure ulcer on the coccyx. The pressure ulcer measured 3 cm. (centimeters) by 1.5 cm. Resident 9 was observed on 10/23/06 from 1:00 PM till 4:30 PM. The resident was observed in bed with no multi-podus boots on. Resident 9 was observed from 10/23/06 to 10/25/06. There was no pressure relieving device in the wheelchair, only an incontinent pad that was folded over. In an interview with resident 9, on 10/24/06 at	F 309	The charge nurse during each shift will make rounds and enter the room of resident 9 to insure that multi-podus boots are on at all times, and that a gel pad is in the wheel chair. A mandatory in-service training will be provided by the Director of Nursing based on this requirement for all nurses and nursing assistants. Individual training will be accomplished for all new hires and staff who do not demonstrate the ability to follow the procedure. The Assistant Director of Nursing will review all orders daily, Monday through Friday to assure that not only resident 1, but all resident orders are taken off in a timely manner, and that additional follow up care has been provided per facility policy. The Director of Nursing will assist with treatments of all pressure ulcers. The progress will be documented and any modifications to the treatment will be reviewed if the desired outcome and healing is not achieved. The evaluation of the treatments will be accomplished not less than weekly.	11-24-06

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F 309	Continued From page 6 1:00 PM, the resident said that staff forgot to put his boots on after giving him a shower. In an interview with the Director of Nursing, on 10/24/06 at 3:30 PM, she confirmed that resident 9 was to have a pressure relieving device in his wheelchair and that he should have the multi-podus boots on at all times. Resident 9's medical record was reviewed on 10/23/06. Resident 9's medical record documented a Braden score (for pressure ulcer risk) which was 11, on 10/12/06, indicating high risk. The admission Minimum Data Set (MDS) assessment documented that resident 9 would have a pressure relieving device in the wheelchair, and the care plan also documented a pressure relieving device in the wheelchair. Resident 9 had physician's orders, dated 10/15/06, for multi-podus boots on at all times. 2. Resident 1 was admitted to the facility 8/31/06 with diagnoses that included chronic pancreatitis, venous insufficiency, joint contractures of forearm, pelvis, and neck, depression disorder, prolonged post traumatic stress disorder and stage III pressure ulcer. Resident 1 ' s medical record was reviewed on 10/23/06. On 8/31/06, there was a physician's order for the	F 309	The Director of Nursing will hold an in-service training based on this requirement with all nurses. Individual training will be provided for new hired staff and any staff who does not demonstrate the ability to follow this training. The Director of Nursing will monitor that this requirement and training is accomplished by perform daily rounds, Monday through Friday, to assure that all treatments are followed as ordered. A Monthly in-service log will be maintained to assure that the Nursing Staff and the CNA's have adequate opportunity to receive training regarding treatment orders. The Director of Nursing will check Physicain Orders weekly when recertification of Physicain Orders are completed. The quality assurance committee will review this process not less than quarterly to insure that the desired outcome and care are achieved. Improvements to this procedure and/or additional training may also be initiated at this time if deemed appropriate.	

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F 309	Continued From page 7 facility to consult the wound clinic after the Labor-Day holiday. On 10/25/06 at10:45 AM, in an interview with the DON, she stated that the Activities Director and she had called and left messages with the wound clinic several times to make an appointment for resident 1, but that the wound clinic did not return the calls. " They (the DON and Activities Director) really didn ' t push it because our nurses are doing wound care and it is getting better. . . . I will ask [name of resident 1's attending physician] to discontinue the wound care order tomorrow. " On 10/24/06 at 4:20 PM, in an interview with a facility licensed practical nurse (LPN) was held. This interview occurred during an observation of resident 1's pressure ulcer treatment. The LPN stated, " The wound is getting worse." The LPN then used a paper tape measure to demonstrate that the resident's wound had been 1/4 inch deep and that it was now 3/4 inch deep.	F 309		

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F 328 SS=D	483.25(k) SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and a review of medical records, it was determined that for 1 of 15 sampled residents the facility did not ensure that a resident with orders for oxygen therapy received the necessary cares and services. Resident 5. Findings include: Resident 5 was admitted to the facility 4/16/04. Her diagnoses included sleep apnea, dementia, obesity, and bipolar personality disorder. Observations of resident 5 were made at various times on 10/23/06, 10/24/06 and 10/25/06. Resident 5 was observed in her room, in a common corridor, in the dining room during meals, and in the dining room during activities. Resident 5 was observed to ambulate with the use of a front wheeled walker to various locations in the facility. At each observation, resident 5 was not using supplemental oxygen, nor was supplemental oxygen available next to her outside	F 328	The charge nurse for each shift will provide education for not only Resident 5, but to all resident of the importance of following mediation and treatment plans. The residents' physician will be notified of any residents who are non-compliant with care and treatment recommendations. Guidelines given by the physician will be followed per facility policy. The Director of nursing will give an in-service to the nursing staff to educate them on the importance of meeting this requirement. The importance of documenting the education steps taken to insure that necessary cares are met will also be accomplished. Individual training will also be given for new hires and for those who do not demonstrate the ability to follow this training and procedure.	11-24-06

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F 328	Continued From page 9 of her room. Observations of resident 5 were as follows: On 10/23/06 at 4:00 PM, resident 5 was observed in a chair in a common corridor, near the vending machines. She was not using supplemental oxygen. On 10/24/06 at 8:00 AM, resident 5 was observed in the dining room, seated at a table. She was not using supplemental oxygen. At 10:15 AM, resident 5 was observed in the facility's smoking room. She was not using supplemental oxygen. NOTE: Using oxygen while smoking would be contraindicated. At 1:15 PM, she was in the dining room, participating in an activity. She was not using supplemental oxygen. At 2:50 PM, resident 5 was sitting in the common corridor, near the vending machines. Resident 5 stated she was on her way to smoke. She was not using supplemental oxygen. On 10/25/06 at 10:30 AM and again at 1:40 PM, resident 5 was observed in the common corridor, near the vending machines. She stated she was on her way to smoke. She was not using supplemental oxygen. On 10/23/06, 10/24/06, and 10/25/06, resident 5's room was observed. Resident 5 was observed to have an oxygen concentrator next to her bed with a nasal cannula connected to it. The concentrator was on wheels and plugged into an electric outlet. An interview with resident 5 was held on 10/25/06 at 1:40 PM. The surveyor asked resident 5 about her use of supplemental oxygen. The resident stated that she knew she was supposed to be using the supplemental oxygen but that she did not like to use it because she could not take it out	F 328	The Director of Nursing will monitor that the procedure and training are accomplished by performing daily rounds Monday through Friday to assure that all treatments are followed and that any additional education necessary is accomplished. A montly in-service log will be maintained to insure that this training is provided for the Nursing and CNA staff to insure that the Facility Policy and Procedure is followed. The Quality Assurance Committee will review this procedure quarterly to insure that the desired outcome and training is being accomplished.	

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F 328	Continued From page 10	F 328		

to smoke. Resident 5 stated that she used the supplemental oxygen at night time.

An interview was held with the Director of Nursing (DON) on 10/24/06 at 2:30 PM. The DON stated that resident 5 was supposed to use supplemental oxygen, at two liters per minute, all the time. The DON also stated that resident 5 refused to use the supplemental oxygen except at night time. The DON did not offer any strategies that the facility had attempted to get resident 5 to use the supplemental oxygen as prescribed by the resident's attending physician.

A review of resident 5's medical record was completed on 10/26/06. On 2/20/06, facility staff completed an annual Minimum Data Set (MDS) assessment for resident 5. Additionally, on 5/11/06 and 8/3/06, facility staff completed quarterly MDS assessments for resident 5. On each of these assessments, facility staff assessed that resident 5 did not use oxygen therapy. Additionally, facility staff assessed that resident 5 had both long and short term memory deficits and had severely impaired cognitive skills for daily decision making. On the 8/3/06 quarterly MDS assessment, facility staff also documented that resident 5 was resistive to cares.

A review of physician orders revealed an order dated 10/20/06. The physician prescribed that resident 5 use supplemental oxygen at two liters per minute by way of a nasal cannula.

A review of treatment records for resident 5, between 10/20/06 and 10/23/06 was completed on 10/24/06. Facility staff documented resident 5's oxygen saturation levels on the treatment

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 11 record. Per documentation, resident 5's oxygen saturation levels were as follows: 10/20/06 in the AM - 88 % 10/20/06 in the PM - 90% 10/21/06 in the AM - 83 % 10/21/06 in the PM - 84 % 10/22/06 in the AM - 85 % 10/22/06 in the PM - 81% up to 85% 10/23/06 in the AM - 81% 10/23/06 in the PM - 83% A review of nursing notes for resident 5, between 10/20/06 and 10/23/06 was completed on 10/24/06. There were no nursing note entries which identified nursing interventions to improve the resident's oxygen saturation level when the saturations were below 90 %. A review of resident 5's comprehensive plan of care revealed that the physician order for oxygen therapy, dated 10/20/06, had not been incorporated into the plan. The facility had not developed strategies to optimize resident 5's respiratory status, taking into account times when the resident may be resistive to cares and inability to use oxygen therapy while smoking. On 10/24/06 at 8:00 AM, the DON provided the surveyors a copy of a Refusal of Treatment form. This form was signed by resident 5 on 10/24/06, and documented that resident 5 refused to use and was aware of possible risks associated with refusing to use supplemental oxygen. Note: This form was completed following the surveyor's discussing resident 5's use of oxygen therapy with facility staff.	F 328	F 468 The hand rail between rooms 105 and 104 have been tightened. The hand rail next to room 108 has been tightened. The hand rail across from the Social Services office has been tightened. There will be a hand rail placed on the wall next to room 104 to eliminate the 43 inch area where no rail was previously present. A hand rail will be placed on the wall next to room 114 to eliminate the 28 inch area where no rail was previously present. A hand rail will be placed in the hall past the Social Service office to eliminate the 34 inch area where no rail was previously present. The hand rail next to room 12 has been tightened. The hand rail next to the nurses work room has been tightened. The hand rail next to the men's bath-room has been tightened.	11-24-06

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

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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 _____	10/26/2006

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

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F 468 SS=B	483.70(h)(3) OTHER ENVIRONMENTAL CONDITIONS - HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation, from 10/24/06 to 10/25/06, it was determined that the facility had three areas in the hallways that were missing hand rails and also had three handrails that were loose. On the Alzheimer's unit there were three hand rails that were found to be loose. Findings include: Hand rail between room 105 and room 104 was loose, Hand rail next to room 108 was loose, Hand rail across from Social Services office was loose, The wall next to room 104 had a 43 inch area with no hand rail present, The wall next to room 114 has a 28 inch area with no hand rail present, The hall past the Social Services office has a 34 inch area with no hand rail present. Alzheimer's unit had the following: Hand rail next to room 12 was loose, Hand rail next to the nurses work room was loose, Hand rail next to the men's bathroom was loose.	F 468	These repairs will be accomplished by the maintenance staff. The maintenance supervisor will monitor that this work is accomplished. The maintenance staff will check the maintenance log daily during each shift that a maintenance staff member is at work, to see if any railing(s) have been reported to be missing or loose. Any railings reported on the list will be tightened or scheduled for repair during that maintenance shift. The maintenance supervisor will include the hand rails on his monthly maintenance checklist to insure that the hand rails are in place and tightened appropriately. Any necessary tightening and/or replacing will be accomplished following each monthly check, or at the time of the monthly check if only a minor adjustment is required. The maintenance supervisor will monitor that this procedure is followed to insure that the hand rails in the facility are present and tightened. The Quality Assurance Committee will review this procedure quarterly to insure that this requirement is met on a continuous basis.	11-24-06