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	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midtown Manor	125 South 900 West Salt Lake City, UT 84104

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, for 1 out of 36 sampled residents, the facility did not ensure that residents were free from abuse. Specifically, a resident with a history of aggressive behavior,who required supervision, struck another resident. Resident identifiers: 18 and 33. Findings included: An entity 358 incident report was submitted to the State Survey Agency on 5/15/24. The report revealed that a smoking aid was taking resident 33 out to assist him to smoke. The smoking aid turned to open the door and resident 33 struck resident 18. The incident happened in the Foyer of the nursing home at approximately 5:35 PM. No serious bodily injury was reported. The report stated that resident 33 had a history of aggressive behaviors and required supervision. The report stated both residents were redirected, with resident 33 being redirected to his room. Resident 33's legal guardian was at the facility at the time of the incident and was informed. Law enforcement and Adult Protective Services were notified. It should be noted that a second incident report was submitted to the State Survey Agency on 5/29/24, where resident 33 struck resident 18 in the back of the head. Resident 33 was sent out for behavior management. The report was closed with no action needed. 1. Resident 18 was admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis following cerebrovascular disease, intellectual disabilities, and schizoaffective disorder. Resident 18's medical record was reviewed between 4/27/25 and 4/30/25. A Minimum Data Set (MDS) quarterly assessment dated [DATE], revealed that resident 18 had a Brief Interview for Mental Status (BIMS) score of 00 suggesting significant cognitive impairment. His assessment also revealed resident 18 had physical behavior symptoms directed toward others 4 to 6 days of the look-back period, but less than daily, verbal behavior symptoms daily and behavioral symptoms not directed toward others that occurred daily. Resident 18's progress notes revealed: (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. On 5/15/24 at 6:00 PM, an Incident note revealed, Resident sitting in geri-chair in foyer waiting to smoke; staff observed another resident punch [resident 18] in the R [right] knee but was unable to intervene in time; resident assessed by nurse, no injuries apparent, resident reports mild pain to R knee and rates at a 3/10; ADON [Assistant Director of Nursing], MD [Medical Doctor] and administrator notified. b. On 5/29/24 at 4:20 PM, an Incident note revealed, Resident sitting in geri-chair in day room talking to staff member; staff observed another resident punch [resident 18] on the R side of the head but was unable to intervene in time; resident assessed by nurse, redness noted to the R ear, resident reports pain to R ear as a 5/10; administrator, DON [Director of Nursing], resident advocate, MD, and police notified. 2. Resident 33 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included schizophrenia, anxiety disorder, major depressive disorder, and cognitive social or emotional deficit following cerebral infarction. On 4/27/25 at 9:42 AM, an interview was conducted with resident 33 who stated he felt he was able to get along with everyone at the facility. Resident 33 stated that the staff may not say that he gets along with everyone. Resident 33's medical record was reviewed between 4/27/25 and 4/30/25. A quarterly MDS assessment dated [DATE], revealed resident 33 had a BIMS score of 10 suggesting moderate cognitive impairment. This assessment also revealed that resident 33 had behaviors directed toward others on 4 to 6 days, but not daily, had verbal behaviors daily toward other residents, and had other behaviors not directed toward others on a daily basis. The assessment revealed resident 33 had mood symptoms of trouble concentrating and sleeping. Physician orders included: a. Depakote extended release Oral tablet; 500 milligrams (mg) by mouth. b. Clozapine Oral tablet 100 mg by mouth. Resident 33's care plan was reviewed. There were no care areas to address resident 33's behaviors directed toward other residents or for monitoring resident 33 for incident prevention. Resident 33's progress notes revealed: a. On 5/15/24 at 5:56 PM, an incident note revealed, Resident escorted from room to smoking room, staff turned to open smoke room door for resident to enter room, when staff turned back resident was observed punching another resident in the R knee; staff unable to intervene in time; guardian, ADON, MD and administrator notified. b. On 5/17/24 at 10:20 PM, an alert note revealed, Resident needs to be reminded to stay away from hallways and high traffic areas and wait for smoke aid to take him to smoke instead of coming out looking for him and to refer to his smoking schedule posted in his room. No further altercations. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. On 5/24/24 at 6:46 AM, a Health Status note revealed, Resident is A & O [alert and oriented] x 2 [person and place], delusional thinking, will act up on paranoia at times, has had restrictions to not smoke around other residents as he has the tendency to strike out without being provoked .Plan of care ongoing. d. On 5/28/24 at 11:43 AM, a No Type Specified note revealed, Resident returned from the Clozaril clinic with the following note, continued delusions and physical altercations, . Invega 234 mg IM [intramuscular] due 6424 [6/4/24], continue medications as ordered, return June 25th. e. On 5/29/24 at 2:00 PM, a Plan of Care Note revealed, IDT [interdisciplinary team] and the legal guardian reviewed and discussed about current plan of care. f. On 5/29/24 at 4:20 PM, an Incident Note revealed, Resident wheeled up to another resident in his W/C [wheelchair] while other resident was talking to staff and unprovoked stood up and punched other resident in the side of the head. staff observed incident but was unable to intervene in time; nurse assessed resident; no apparent injures [sic]; Administrator, DON, resident advocate, guardian, MD, and police notified. g. On 5/29/24 at 6:05 PM, an Order note revealed, New order: transfer to [name of facility redacted] ED [emergency department] via ambulance for danger to others. h. On 5/29/24 at 6:30 PM, a Transfer to Hospital Summary revealed, Resident 33 was transferred to [name of facility redacted] ED via [name redacted] ambulance. Paramedics accompanied. On 4/30/25 at 3:31 PM, an interview was conducted with Certified Nursing Assistant (CNA) 2 who stated staff checked on resident 33 multiple times per day. CNA 2 stated resident 33 had calmed down quite a bit. CNA 2 stated resident 33 used to go outside to smoke with other residents, but he started smoking by himself, then started smoking alone in the smoking room, and now he does not smoke at all. CNA 2 stated resident 33 and resident 18 did not get along. CNA 2 stated resident 33 and resident 18 no longer interacted with each other. CNA 2 stated resident 33's behaviors had improved. CNA 2 stated she was not aware of any particular interventions that had been put into place to prevent altercations between resident 33 and resident 18, but the residents did not interact with each other and there had been no problems. On 4/30/25 at 3:56 PM, an interview was conducted with Registered Nurse (RN) 1 who stated resident 33 was a quiet resident. RN 1 stated resident 33 spent a lot of time in his room. RN 1 stated staff monitored resident 33 closely and she and the Resident Advocate (RA) spent a lot of time with resident 33, taking him for walks, and taking him shopping. RN 1 stated resident 33 did not verbalize his feelings and when things would build up it would just all come out. RN 1 stated resident 18 was very loud and had behaviors constantly. RN 1 stated resident 18 wanted to go out and smoke constantly and aggravated other residents constantly. RN 1 stated when resident 33 hit resident 18 it was intentional. RN 1 stated the RA was constantly going to resident 33's room, and taking him to activities. RN 1 stated the nurses notes should state how residents were being monitored. RN 1 also stated she was not sure if there was a care plan for resident 33's behaviors.