STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465124	A. BUILDING _____ B. WING _____	**09/28/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** Based on observation and interview, it was determined the facility failed to properly implement prevention strategies related to COVID-19. Specifically, a staff member was observed in the facility without an N95 mask during a COVID 19 outbreak. In addition, a dietary cart was removed from the COVID-19 unit and taken into the non-COVID 19 areas without being sanitized. Findings include: 1. On 9/21/2020 at 12:20 PM, the survey team entered the facility. The Director of Nursing (DON) was observed to screen the surveyors by checking their temperature and asking if they had any symptoms of COVID-19. The DON stated that another staff member was in charge of screening individuals who entered the facility. The DON stated she did not know where the assigned staff member for screening was. Another staff member was observed to enter with the surveyors and stated to the DON that he needed his pay check. This staff member stayed in the facility, by the Administrator's door, outside resident rooms, for 15 minutes without an N95 mask on. On 9/21/2020 at 12:30 PM, Certified Nursing Assistant (CNA) 1 was observed to be in the COVID-19 unit. CNA 1 was observed with the a gown, N95 mask, surgical mask, face shield and gloves. CNA 1 approached the plastic curtain and stated that while in the COVID-19 positive unit, all staff were required to wear full personal protective equipment (PPE). CNA 1 stated that everything they used in that unit was disposable and they discarded the used PPE into red plastic bags that were it was disposed of by the housekeeping multiple times per day. CNA 1 stated that no items or equipment was supposed to be taken from the COVID-19 unit without proper cleaning. On 9/21/2020 at 12:40 PM, Registered Nurse (RN) 1 was observed in the COVID-19 unit with full PPE on. RN 1 stated that all employees assigned to the COVID-19 positive unit were required to wear a gown, N95, surgical mask, face shield and gloves while working in the unit. RN 1 stated that anything used in the unit was disposable and nothing was taken from the unit without proper cleaning. On 9/21/2020 at approximately 12:30 PM, that Administrator was interviewed. The Administrator stated that all staff were required to wear N95 masks, face shields, gowns, booties and gloves when working with COVID-19 positive residents. The Administrator stated that all staff member wore an N95 mask and face shield while in the facility. 2. On 9/21/2020 at 12:48 PM, an observation was made of the facility COVID-19 positive unit. An observation was made of the Dietary Manager (DM) in the area between the COVID-19 positive unit and the non-COVID-19 unit. The DM was observed to reach in the plastic curtain and pull out a cart with coffee pots on it. The DM was observed to be wearing a mask and face shield. The DM was not observed to have gloves or a gown on. The DM pulled the cart into the elevator. It should be noted that the kitchen was located in the basement of the facility. On 9/23/2020 at 2:10 PM, a phone interview was conducted with the DM. The DM stated that all resident with COVID-19 were receiving their meals and snacks on disposable plates and utensils. The DM stated that the disposable plates and utensils were initiated on 9/17/2020. The DM stated that nothing was returned to the kitchen after entering the COVID-19 positive unit. The DM stated that the kitchen staff used bleach to sanitize anything brought into the kitchen. The DM did not answer why she had wheeled a cart out of the plastic curtain and into the elevator with coffee pots on it. The DM stated that nothing in the COVID-19 positive unit would have been taken to the kitchen. The DM stated if anything was taken to the kitchen then the kitchen staff would disinfect it with a bleach solution. The DM stated that resident's who tested negative for COVID-19 received their food on regular plates and regular utensils. The DM stated that the plates and utensils were placed in a bleach solution and then ran through the dish machine twice. The DM stated that she was monitoring the dish machine temperatures and sanitizer solution closely. On 9/24/2020 at 10:47 AM, a phone interview was conducted with the DON. The DON stated that all residents were receiving their food on disposable plates and utensils. The DON stated that nothing was taken to the kitchen from the COVID-19 positive unit. On 9/28/2020 at 1:00 PM, a phone interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated that she noticed the coffee cart was taken out of the COVID-19 unit by the DM. The ADON stated that she re-educated the DM about not removing items from the COVID-19 positive unit and taking them to the kitchen. On 9/28/2020 at 1:00 PM, a phone interview was conducted with the Administrator. The Administrator stated that he bought new carts dedicated to the COVID-19 positive unit. The Administrator stated that the carts should not be taken out of the COVID-19 positive unit.

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