STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265736	A. Building B. Wing	12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
U-City Forest Manor	1301 Partridge Avenue Saint Louis, MO 63130

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 46970 Based on interview and record review, the facility failed to ensure resident care plans reflected current needs when staff failed to include speech therapy recommended choking strategies for one resident with a history of choking (Resident #1). The sample was five and issues were found with one. The census was 81. Review of the facility's Baseline Plan of Care policy, last revised 08/2017, showed: -The baseline care plan must reflect the resident's stated goals and objectives and include interventions that address his or her current needs. Because the baseline care plan documents the interim approaches for meeting the resident's immediate needs, professional standards of quality care would dictate that it must also reflect changes to approaches, as necessary. Facility staff must implement the interventions to assist the resident to achieve care plan goals and objective; -If the comprehensive assessment and comprehensive care plan identified a change in the resident's goals, or physical, mental, or psychosocial functioning, which are not identified in the baseline care plan, those changes must be incorporated into an update summary provided to the resident and his or her representative; -Additional changes will be made to the comprehensive care plan based on the assessed needs of the resident, however, these subsequent changes will not need to be reflected in the summary of the baseline care plan. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 9/17/24, showed: -Severe cognitive impairment; -Diagnoses included: anxiety disorder (intense, excessive, and persistent worry and fear about everyday situations), aphasia (a language disorder that affects a person's ability to speak), stroke, Transient Ischemic Attack (TIA, a brief episode of stroke-like symptoms that occurs when blood flow to the brain is temporarily cut off); -Coughing or choking during meals or when swallowing medications, mechanically altered diet, and therapeutic diet. (continued on next page)

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.

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's care plan, in use during the survey, showed: -Problem: Resident is at risk for choking/swallowing issues related to dysphasia diagnosis. On 8/24/24 choked on a breadstick, chest x-ray negative; -Goal: Resident will not suffer serious injuries related to aspiration and intake of nutrients will meet metabolic needs; -Approaches included: -Speech therapy (ST) to evaluate and treat related to choking incident; -Diet: mechanical soft diet with thin liquids, super cereal (nutritional supplement) and whole milk at breakfast. Health shake (nutritional supplement) with each meal. NO BREAD!!; -Please check face, hands, nails, clothes, mouth for hygienic needs before and after each meal and as needed; -Resident eats in Courtyard dining room or room as desired/needed; -Monitor/document signs/symptoms of dysphasia: Pocketing (hold food in mouth instead of swallowing), choking, coughing, drooling, holding food in mouth. Several attempts at swallowing; -Resident can feed self after set up. Assist with tray set up and eating as needed; -Make sure resident is in the proper position for all meals. Review of the resident's progress notes, showed: -8/24/24, while eating dinner, resident began to choke. Heimlich maneuver and mouth sweep performed. Was able to remove half of the bread stick that was served with dinner. Resident never lost consciousness and was encouraged to cough. Vital signs within normal limit. States it scared him/her; -8/26/24 at 11:13 A.M., new verbal order received from Nurse Practitioner. ST evaluation and treat related to choking incident; -8/29/24 at 12:43 P.M., resident eats very fast and does not chew food up. Gulps liquids. He/She has to be redirected frequently at meals. New order per physician for speech to evaluate and treat as needed; -8/31/24 at 1:25 P.M., resident is on a mechanical soft diet. Received whole slice of pizza for lunch meal and began to choke on pizza. Most of pizza cut up for resident to eat. New order added to diet for no bread. Diet slip made out and given to dietary staff. Review of the resident's ST notes, showed: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-8/28/24, resident challenged with safe swallowing compensatory strategies and ST discussed safety risks associated with aspiration/choking, etc. Resident stated, I need to slow down. Nursing and nursing aides on unit are aware of resident complex needs and cues needed regarding rate of intake and amount of meal consumed when discussed. Resident followed compensatory strategies with 60% accuracy independently and 100% with moderate/maximum verbal cues; -9/3/24, showed resident was reported to have had increased difficulty consuming pizza over the weekend, additional choking episode. Resident orders are mechanical soft without bread. ST to continue monitoring for signs and symptoms of aspiration/choking of mechanical soft. Resident may need downgrade to puree. Continue with plan of care. Review of the ST discharge recommendations, dated 9/5/24, included: -Supervision: Close supervision; -Recommendations: To facilitate optimal cognitive-communicative performance, the following strategies are recommended: Training in use of concrete, one step directions by speaker to increase comprehension; -Solids: Soft/Ground/Chopped textures; -Strategies: To facilitate safety and efficiency, it is recommended the resident use the following strategies and/or maneuvers during oral intake: General swallow techniques/precautions, bolus size modifications, rate modification and alternation of liquids/solids, upright posture during meals. Review of the resident's care plan, revised on 9/25/24, showed: -Problem: Resident receives ST therapy three times a week for two weeks related to two choking incidents. Therapy sessions are held in the therapy area; -Goal: Resident will accomplish goals as specified on his/her therapy treatment plan; -Approaches included: Monitor progress. Therapist and nursing to collaborate care and services to maximize resident's accomplishments; -Did not address any of the ST discharge recommendations. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interviews on 12/3/24 at 1:28 P.M. and 12/6/24 at 9:04 A.M., the Speech Therapist said she knew the resident. He/She was on a mechanical soft diet, nectar thick liquids, and no bread. She said the resident wasn't compliant with his/her diet. The resident coughed when he/she ate things outside of his/her diet and would aspirate as well. The resident had a history of choking. She remembered the resident choking on a breadstick and he/she sometimes took food from other residents' plates. The resident needed a lot of cues to slow down at meals. The resident was impulsive and would wheel himself/herself up to other residents' trays and take their food. The Speech Therapist said staff had to make sure the resident's food was cut up appropriately, the resident was to be under supervision, and was not allowed to eat in his/her room. She talked to the nurses and aides about the resident needing extra help with eating. She would sit with the resident at the assist table and cue him/her to slow down. As she was providing cues, she would educate staff at that time. Nursing provided staff with their own education, from a nursing standpoint. She defined close supervision as being arm's length away. She expected staff to be arm's length away from the resident when eating. A staff member would need to be with him/her. He/She needed to be at the assist table and couldn't be at a table without staff. If the resident was seated at the assist table, there would have been someone sitting at the table with him/her during the meal. During an interview on 12/4/24 at 10:02 A.M., Certified Nurse Aide (CNA) A said meal set up for residents included passing the tray, taking off the plastic and placing silverware and drinks on the table in front of the resident. Some residents needed help with eating, and some didn't. If a resident needed help eating, the resident got his/her tray last. He/She knew the resident and worked with the resident on the last day CNA A was at the facility. The resident was on a mechanical soft diet. Sometimes you had to tell the resident to slow down. The resident didn't sit by other residents and was at a separate table from the other residents. The resident had to be at a table by himself/herself, because he/she would take food off the other residents' plates. There were no special instructions for staff on what to do after the resident's mealtime. Staff would check on the resident after meals. He/She didn't know the resident's care plan said to check him/her for pocketing food in his/her mouth. CNA A said pocketing was when a resident put food in his/her pocket to eat later. During a telephone interview on 12/6/24 at 11:13 A.M., Licensed Practical Nurse (LPN) C said he/she was aware the resident was supposed to take small bites during meals. LPN C would assist another resident during mealtime, but would tell the resident to slow down and take a drink. He/She said the resident ate like someone was going to snatch his/her food, so the resident always had to be redirected. The resident always ate in the dining room. LPN C said all of the swallowing strategies and close level of supervision should have been on the resident's care plan. During a telephone interview on 12/4/24 at 11:42 A.M., LPN B said he/she knew the resident and he/she was a fast eater. The resident used to cough, but ST started working with him/her. LPN B said he/she tried to keep the resident within his/her line of sight when the resident ate, because he/she ate fast. The resident ate in the dining room. LPN B said the only instructions after meals was the resident was not allowed to get in bed right after his/her meal. He/She said pocketing was when a resident held food inside of his/her cheek and/or mouth. LPN B had seen the resident hold food in his/her mouth before, but it had been quite some time ago. He/She didn't know pocketing/holding food in mouth was in the resident's care plan. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/10/24 at 12:18 P.M., the MDS Coordinator said she was responsible for updating resident care plans. She said she wasn't aware to the Speech Therapy recommendations for the resident. Speech Therapy was supposed to bring her a notice related to the changes in a resident's care plan. She didn't receive a notice from Speech Therapy regarding changes for the resident. The MDS Coordinator said if she had known about the recommendations, she would have updated the resident's care plan. She expected the resident's care plan to be updated. During an interview on 12/6/24 at 11:58 A.M., the Assistant Administrator and Assistant Director of Nursing (ADON) both said they were not aware of the ST discharge summary recommendations. They both said the ST strategies and close supervision should have been care planned. They both said it was rare for the MDS Coordinator to miss things. The Assistant Administrator said she, the ADON, and the MDS Coordinator normally looked over the ST notes but the MDS Coordinator was responsible for updating resident care plans. The ADON said the MDS Coordinator said she read over the recommendations, but wasn't sure why they were not added to the resident's care plan. They both expected the ST recommendations to be added to the resident's care plan. MO00245954

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46970 Based on interview and record review, the facility failed to provide adequate supervision, by not ensuring staff were within arm's reach of a resident with a diagnosis of dysphasia (trouble swallowing) and a history of choking (Resident #1). On [DATE], the resident choked during lunch while eating alone at a table in the dining room. Staff intervened and were unsuccessful with clearing the resident's airway and performed lifesaving measures until emergency medical staff (EMS) arrived. EMS staff were eventually able to dislodge a large piece of broccoli, a food that was not served on the resident's lunch tray. Resident #1 expired. The sample size was 5. The census was 81. The Administrator was notified on [DATE] at 4:00 P.M., of an Immediate Jeopardy (IJ) which began on [DATE]. The IJ was removed on [DATE], as confirmed by surveyor onsite verification. Review of the facility's Change in Condition policy, revised ,d+[DATE], showed: Definition: -Change in condition is defined as an improvement or decline in the resident's physical, mental or psychosocial status that effects two or more areas of activities of daily living (ADL); -Significant change is defined as an improvement or decline in the resident's physical, mental or psychosocial status that effects two or more areas of ADL; Procedure: -The staff person who first notices the change reports resident change in condition immediately to the licensed nurse; -The resident's primary physician or designated alternate will be notified immediately of any change in resident's physical or medical condition, this includes: -Accident involving the resident; -Deterioration in health, mental, or psychosocial status; -Need to alter treatment (i.e. need to discontinue an existing form of treatment due to adverse consequences or to commence new form of treatment); -Notification of physician and/or responsible parties shall be documented in the clinical record as well as on the 24-hour report form. Status changes, which are not significant enough to be reported, must also be documented in the medical record; -All changes of condition must be completely and objectively documented in the clinical chart; (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Appropriate follow through from shift to shift is imperative for all residents with any change in condition. The nursing staff must utilize the tools provided for formal communication from shift to shift. Review of the facility's Safety and Supervision of Residents policy, (no date), showed: -Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Procedure: -Our facility-oriented approach to safety risks for groups of residents; -Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes; reviews of safety and incident/accident reports; and a facility-wide commitment to safety at all levels of the organization; -When accident hazards are identified, the facility shall evaluate and analyze the cause(s) of the hazards and develop strategies to mitigate or remove the hazards to the extent possible; -Employees shall be trained and in-serviced on potential accident hazards and how to identify and report accident hazards and try to prevent avoidable accidents; -The facility shall monitor interventions to mitigate accident hazards in the facility and modify as necessary; -Staff shall use various sources to identify risk factors for residents, including the information obtained from the medical history, physical exam, observation of the resident, and the Minimum Data Set (MDS, a federally mandated assessment instrument required to be completed by facility staff); -The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for that resident. The care team shall target interventions to reduce the potential for accidents; -The facility-oriented and resident-oriented approaches to safety are used together to implement a systems approach to safety, which considers the hazards identified in the environment and individual resident risk factors, and then adjusts interventions accordingly; -Resident supervision is a core component of the system approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment; -The type and frequency of resident supervision may vary among residents and over time for the same resident. For example, resident supervision may need to be increased when there are temporary hazards in the environment (such as construction) or if there is a change in the resident's condition. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's Interdepartmental Notification of Diet (including changes and reports), dated 2001, revised ,d+[DATE], showed: Policy Interpretation and Implementation: Nursing services shall notify the Physician and Dietitian when a nutritional problem (e.g., eating problem) has been identified and shall collaborate with the Dietitian and Physician to initiate an appropriate process of clinical review for causes of the nutritional problem. Review of the facility's Consistency Modified Diets policy, revised ,d+[DATE], showed: -The following diets are modified in texture to promote ease of chewing and swallowing. No two patients/residents are alike; therefore, diets must be individualized based on their chewing/swallowing ability; -Please have your staff Registered Dietitian (RD) and/or Speech Therapist review these diets to assure appropriateness for each patient/resident. Based on individual patient/resident tolerance and community standards, some menu items, including liquids, may need to be altered; -Mechanical Soft: This diet is used for patients/residents with limited chewing ability. Foods menus include ground moist meats, poultry, and fish (without bones), canned fruits and vegetables, well-cooked, soft vegetables, finely chopped fresh fruits and vegetables as tolerated, soft breads and desserts. Recipes with the abbreviation NRV (No Raw Vegetables) at the end indicate they need to be made without raw vegetables. These food and others may or may not be allowed based on individual patient/resident tolerance; -Pureed: This diet consists of pureed, homogenous, and cohesive foods. Food should be pudding-like, no coarse textures, raw fruits or vegetables, nuts, etc., are allowed. Any foods that require bolus (the process of breaking down food into a soft, ball-like mass that can be swallowed), controlled manipulation, or mastication (chewing) are excluded. This diet is designed for people who have moderate to severe dysphagia, with poor oral phase abilities and reduced ability to protect their airway. Close or complete supervision and alternate feeding methods may be required. Thin liquids should be thickened as ordered as this diet was written assuming no modification for liquids (i.e. liquids of regular consistency are modified). Review of the facility's Diet spreadsheet, showed: -[DATE], Dinner: Mechanical Soft - Ground chicken croquet, mashed potatoes, broccoli, cornbread, mixed melon, gravy, margarine, 2% milk, coffee/Tea; -[DATE], Lunch: Mechanical Soft - Ground Cod, potato wedges, cooked cabbage, wheat bread, snickerdoodle cookie, margarine, coffee/tea; -Diet spreadsheet showed no broccoli on [DATE]. Review of Resident #1's Quarterly Review MDS, dated [DATE], showed: -Severe cognitive impairment; (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Diagnoses included: anxiety disorder (intense, excessive, and persistent worry and fear about everyday situations), aphasia (a language disorder that affects a person's ability to speak), stroke, Transient Ischemic Attack (TIA, a brief episode of stroke-like symptoms that occurs when blood flow to the brain is temporarily cut off); -Coughing or choking during meals or when swallowing medications, mechanically altered diet, and therapeutic diet. Review of the resident's progress notes, showed: -[DATE] at 1:51 P.M., resident eats in Courtyard dining room. Feeds himself/herself. In a wheelchair, will move about on his/her own; -[DATE] at 12:31 P.M., appetite usually good. Sometimes he/she will try and eat off other residents' plates; -[DATE], while eating dinner, resident begin to choke. Heimlich maneuver and mouth sweep performed. Was able to remove half of the bread stick that was served with dinner. Resident never lost consciousness and was encouraged to cough. Vital signs within normal limit. States it scared him/her; -[DATE] at 11:13 A.M., new verbal order received from Nurse Practitioner. Speech Therapy (ST) evaluation and treat related to choking incident. Review of the resident's physician order sheet, showed: -Received and started: [DATE], ST evaluation and treat as indicated. Resident evaluation and treatment completed at this time. Resident to receive ST services 3 times a week for two weeks for oral dysphagia; -Start date: [DATE], ST evaluate and treat related to choking incident; -Start date: [DATE], ST evaluate and treat as needed; -Start date: [DATE], thin liquids with mechanical soft diet. NO BREAD. Review of the resident's ST treatment encounter note, dated [DATE], showed: -Dysphagia therapy: 30 minutes; -Swallowing evaluation: 30 minutes; -Resident referred to ST services per nursing staff based on choking incident [DATE]. Resident choked on a breadstick and the Heimlich maneuver was performed with mouth sweep. Reported that staff was able to remove half of a bread stick that was served with dinner. Resident never lost consciousness and was encouraged to cough. Resident has oral dysphagia, staff training is necessary at this time, assessment of current diet, and safe swallowing strategies required. Resident demonstrates unsafe swallowing with large bites, poor attention to task, and attempts to communicate with food in his/her oral cavity. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the resident's ST notes, dated [DATE], showed resident challenged with safe swallowing compensatory strategies and ST discussed safety risks associated with aspiration/choking, etc. Resident stated, I need to slow down. Nursing and nursing aides on unit are aware of resident complex needs and cues needed regarding rate of intake and amount of meal consumed when discussed. Resident followed compensatory strategies with 60% accuracy independently and 100% with moderate/maximum verbal cues. Review of the resident's progress notes, showed: -[DATE] at 12:43 P.M., resident eats very fast and does not chew food up. Gulps liquids. He/She has to be redirected frequently at meals. New order per physician for speech to evaluate and treat as needed; -[DATE] at 1:25 P.M., resident is a mechanical soft diet. Received whole slice of pizza for lunch meal and began to choke on pizza. Most of pizza cut up for resident to eat. New order added to diet for no bread. Diet slip made out and given to dietary staff. Review of the care plan, showed staff did not address the resident's choking incident on [DATE]. Review of a ST note, dated [DATE], showed resident was reported to have had increased difficulty consuming pizza over the weekend, additional choking episode. Resident orders are mechanical soft without bread. ST to continue monitoring for signs and symptoms of aspiration/choking of mechanical soft. Resident may need downgrade to puree. Continue with plan of care. Review of the ST discharge recommendations, dated [DATE], included: -Supervision: Close supervision; -Recommendations: To facilitate optimal cognitive-communicative performance, the following strategies are recommended: Training in use of concrete, one step directions by speaker to increase comprehension; -Solids: Soft/Ground/Chopped textures; -Strategies: To facilitate safety and efficiency, it is recommended the resident use the following strategies and/or maneuvers during oral intake: General swallow techniques/precautions, bolus size modifications, rate modification and alternation of liquids/solids upright posture during meals. Review of the resident's care plan, showed staff did not address any of the ST discharge recommendations. Review of the resident's progress notes, showed: -[DATE], at 12:36 P.M., the resident has been on a regular mechanical soft diet with thin liquids. He/She had a choking incident on [DATE] on a bread stick, another choking incident on chopped pizza; (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-[DATE] at 12:40 P.M., edited [DATE] at 2:42 P.M., called to assist resident who was in the dining room eating lunch. Resident was choking. Resident alert and is coughing. Did Heimlich maneuver on resident, but unable to get food out. Resident had baked fish, mashed potatoes, and diced peaches for lunch. Assistant Director of Nursing (ADON) notified and Yankauer suction catheter (a ridged, hollow, plastic, or stainless-steel tube used to remove mucus or saliva from the mouth or throat) to try and remove food without success. 911 called and made dispatcher aware resident was choking while eating lunch and had food lodged in throat. Made dispatch aware Heimlich was used several times without success. Also used Yankauer suctioning catheter without success. Made dispatch aware the resident was alert and still responding, but food was still lodged in his/her throat. Dispatch stated they had already dispatched paramedics. Resident remains sitting up in wheelchair. After approximately ,d+[DATE] minutes resident became very anxious. Taking very shallow breaths. Had Certified Nurse Assistant (CNA) run up front to make ADON aware and if 911 was here to have them hurry to resident. Licensed Practical Nurse (LPN) C and Certified Medication Technician (CMT) assisted resident to floor to start using Ambu bag (bag valve mask, a handheld device that provides positive pressure ventilation to patients who are not breathing or not breathing adequately) when paramedics x2 came in and we were instructed by them to get resident up to bed. Paramedic attempted to check airway, unable and asked that the resident be laid back on the floor. Resident assisted back on floor and no pulse palpated and Cardiopulmonary Resuscitation (CPR, an emergency life saving procedure that is done when someone's breathing or heartbeat has stopped) started. Paramedic again went to check airway and removed food. Removed a very large piece of unchewed broccoli that was not on resident's plate. Even after broccoli was removed CPR was continued with resident being suctioned. Resident was assisted with CPR continued to stretcher and leave of absence (LOA) to hospital. ADON made aware resident choked on broccoli that wasn't on his/her plate. The resident had to have taken it from someone else. Notified physician and emergency contact. Review of the resident's hospital Death Summary, dated [DATE] at 3:05 P.M., showed: -Past medical history significant for CVA (stroke) with residual dysarthria (a motor speech disorder that makes it difficult to speak clearly), and left sided weakness, and vascular dementia (a condition that affects the brain's ability to think, remember, and behave, caused by damage to blood vessels from reduced blood flow). He/She presented to emergency department for evaluation of choking status post (s/p) cardiac arrest (occurs when the heart suddenly stops beating, preventing blood from flowing to the brain and other vital organs) and return of spontaneous circulation (ROSC). Per EMS, patient choked on broccoli at lunch in the nursing home. Nursing home staff called EMS and started Heimlich maneuver which EMS continued on arrival. The resident subsequently went into cardiac arrest for which he/she received CPR for thirty-two minutes, two doses of epinephrine (a hormone and medication that plays a key role in the body's fight-or-flight response) and was intubated (insert a tube into a person or a body part, especially the trachea for ventilation) with subsequent removal of the obstructing piece of broccoli in the field. Antibiotics were initiated for aspiration pneumonia; -As per family wishes, he/she was transitioned to comfort only with plan for terminal extubation (removal of tube from a patient's throat and windpipe); -At 4:38 P.M., the resident was pronounced (dead). (continued on next page)

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	265736	A. Building B. Wing	12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
U-City Forest Manor	1301 Partridge Avenue Saint Louis, MO 63130

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interviews on [DATE] at 1:28 P.M. and [DATE] at 9:04 A.M., the Speech Therapist said she knew the resident. He/She was on a mechanical soft diet, nectar thick liquids, and no bread. She said the resident wasn't compliant with his/her diet. The resident coughed when he/she ate things outside of his/her diet and would aspirate as well. Mechanical soft was the most appropriate diet for the resident. The resident had a history of choking. She talked to the nurses and aides about the resident needing extra help with feeding. She would sit with the resident at the assist table, cue him/her to slow down. As she was providing cues, she would educate staff at that time. Nursing provided staff with their own education, from a nursing standpoint. She defined close supervision as being arm's length away. She expected staff to be arm's length away from the resident when eating. A staff member would need to be with him/her. The resident needed to be at the assist table and couldn't be at a table without staff. If the resident was seated at the assist table, there would have been someone sitting at the table with him/her during the meal. She didn't know the resident sat at a separate table to keep him/her from taking food from other residents' plates. She said she remembered him/her choking on a breadstick and he/she sometimes took food from other residents' plates. After the breadstick choking incident, she talked to the kitchen staff about what was appropriate for mechanical soft diet. She wasn't aware the resident had gotten a whole slice of pizza. She said pizza was appropriate for mechanical soft diet, because it had sauce on it, but should have been cut up into bite sizes. The resident had swallowing issue, but he/she could chew. The resident needed a lot of cues to slow down at meals. She said the resident was impulsive and would wheel himself/herself up to other residents' trays and take their food. The Speech Therapist said staff had to make sure the resident's food was cut up appropriately, the resident was to be under supervision and was not allowed to eat in his/her room. Broccoli was acceptable for mechanical soft diet as long as it was the right size and right consistency of softness. She was told kitchen staff would get specific training on diets by someone to show what appropriate consistency, right size, right texture, and how to thicken liquids. The training the kitchen staff received would be passed on to the nursing staff so they could recognize when residents were not getting appropriate food texture, size, and/or consistency of food. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on [DATE] at 10:02 A.M., CNA A said meal set up for residents included passing the tray, taking off the plastic, placing silverware and drinks on the table in front of the resident. Some residents needed help with eating, and some didn't. If a resident needed help eating, the resident got his/her tray last. The tray was supposed to come from dietary in the right diet food texture for the resident. Dietary knew what the residents were supposed to have. He/She knew the resident and was worked with the resident on the last day CNA A was at the facility. The resident was on a mechanical soft diet. Sometimes you had to tell the resident to slow down. The resident didn't sit by other residents and was at a separate table from the other residents. The resident had to be at a table by himself/herself, because he/she would take food off the other residents' plate. The resident didn't eat in his/her room at all. CNA A didn't deliver the resident's tray that day, but was the one who caught him/her choking. CNA A said the resident got baked fish, broccoli, cauliflower, peaches, and mashed potatoes. The resident had no broccoli on his/her plate and CNA A said he/she wasn't sure if the resident ever had broccoli on his/her plate, because when CNA A cleaned up there wasn't any broccoli remnants on the resident's plate. That day, the resident had to be told several times to go back to his/her table. CNA A said he/she turned around and saw the resident choking and told him/her to spit out the food and called the nurse because the resident was choking. When CNA A saw the resident coughing, the resident had mashed potatoes, fish, and peaches in his/her mouth, all at once. He/She told the resident to spit it out and said, You ate all of that at one time? The CMT and nurse came. The CMT put a spoon down the resident's throat to make him/her spit up/vomit. The nurse started the Heimlich maneuver. Someone went to get the suction. The nurse sent him/her to see if the ambulance had arrived. The nurse was suctioning the resident. EMS put a camera down the resident's throat. They saw broccoli and pulled it out. The resident was still unresponsive. He/She thought the resident was already dead. CNA A said that was the first time he/she knew the resident didn't chew the food up. He/She didn't know the resident was just swallowing the food. He/She had teeth, so CNA A didn't know. There were no special instructions for staff to do after the resident's mealtime. Staff would check on the resident after meals. He/She didn't know the resident's care plan said to check him/her for pocketing food in his/her mouth. CNA A said pocketing was when a resident put food in his/her pocket to eat later. The Diet Spreadsheet dated [DATE], showed coleslaw for regular diets and cooked cabbage for mechanical soft diets. There was no documentation of what the substitution for cabbage was. CNA A mentioned broccoli as a vegetable the resident may have gotten, but said there was no sign of broccoli on his/her plate, so he/she wasn't sure. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on [DATE] at 11:13 A.M., LPN C said he/she was called by the Certified Medication Technician (CMT) or CNA and was told the resident was choking, but able to talk. The resident was sitting at a table by himself/herself. He/She did the Heimlich several times and swept the resident's mouth but he/she was biting down, so was difficult to do. LPN C sent the aide to get the Assistant Director of Nursing (ADON). He/She was still doing the Heimlich on the resident. LPN C said he/she looked down at the resident's plate and saw baked fish, mashed potatoes, and diced peaches. They tried to suction the resident with a Yankauer. The resident was alert and still talking. He/She called 911 after they couldn't get the food out of the resident's throat and was still doing the Heimlich. They took the resident to his/her room and continued the Heimlich and suctioning. The resident made some kind of noise and LPN C thought that was when the food went down his/her throat. He/She couldn't breathe. The resident was laid on the floor and CPR was started. They had just gotten the resident to the floor when one of the paramedics said to get the resident onto his/her bed. The paramedic was trying to get a tube down the resident's throat, but couldn't do it with the resident on his/her bed. The resident was moved back to the floor. The paramedics were still trying to get an airway. The resident was suctioned again, because a lot of mucus was coming out. Paramedics had a scope with a camera to look into the resident's mouth. Forceps were used to pull broccoli out. Afterwards, the paramedic was able to get the tube down the resident's throat. When the Fire Department came, they put the chest compression machine on the resident. The paramedics continued CPR while putting the resident on the stretcher. LPN C said he/she had no idea where the resident got broccoli from. LPN C said the CNA (CNA A) said he/she usually passed the resident's meal tray but didn't that day. LPN C asked the CNA if the resident had broccoli on his/her plate and the CNA said no. It was a nice size piece of broccoli, and it was hard. It would have been something he/she would have had to cut up. LPN C said he/she didn't know how the resident was even able to swallow it whole like that. It's mainly the same staff working back in the Courtyard dining area, so they know what diets residents have and the diets are on the mealtime cards that come with the trays. LPN C said he/she was aware the resident pocketed and held food in his/her mouth. He/She told Dietary about the breadstick the resident choked on. He/She was able to get the bread out, but told Dietary not to send the resident bread. LPN C said close supervision was for the ones you knew had problems with swallowing and needed to be watched. He/She said staff were to be in proximity as possible. While staff did other things, they just looked over to check on the resident as best they could. Normally there was a nurse, two CNAs and a CMT. LPN C said he/she was aware the resident was supposed to take small bites during meals. He/She would assist another resident during mealtime, but would tell the resident to slow down and take a drink. He/She said the resident ate like someone was going to snatch his/her food, so the resident always had to be redirected. The resident always ate in the dining room. LPN C said all of the swallow strategies and close level of supervision should have been on the resident's care plan. During a interview on [DATE] at 11:42 A.M., LPN B said he/she knew the resident and he/she was a fast eater. The resident used to cough, but ST started working with him/her. LPN B said he/she tried to keep the resident within his/her line of sight when the resident ate, because he/she ate fast. The resident ate in the dining room. LPN B said the only instructions after meals was the resident was not allowed to get in bed right after his/her meal. LPN B wasn't working the day the resident choked on broccoli. LPN B had seen the resident hold food in his/her mouth before, but it had been quite some time ago. LPN B said nursing would let the CNAs know about diet changes, but didn't know if the information was in the CNA's system. He/She said the diet change was care planned. Once the diet was changed, the order was given to dietary, and a new meal ticket was generated. He/She didn't know pocketing/holding food in mouth was in the resident's care plan. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During and interview on [DATE] at 11:58 A.M., the Assistant Administrator said the facility didn't complete an investigation related to the resident's choking incident. She said the resident expired on [DATE]. She said close supervision was staff being within the vicinity of the resident to watch and oversee. Staff should have been close enough to observe and assist. The Assistant Administrator and ADON both said they were not aware of the ST's mealtime strategies and/or close supervision discharge recommendations. The ADON said the resident was in a secure area, so he/she always had direct supervision in the dining room. She was aware the resident would take food from other resident's plates and had to be redirected back to his/her table. She wasn't aware of the resident sitting at his/her own separate table. As she helped ST recommendations through the facility's regular communication process, she would have expected staff to follow the recommendations. During an interview on [DATE] at 3:59 P.M., both the Administrator and ADON said they expected staff to know what pocketing food was. They expected staff check the resident's mouth for pocketing/holding food in his/her mouth. Note: At the time of the survey, the violation was determined to be at the immediate jeopardy level J. Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective actions to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of the exit, the deficiency was lowered to the D level. This statement does not denote the facility has complied with state law (section 198.026.1 RSMO) requiring that prompt remedial action to be taken to address Class I violation(s). MO00245954