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	02/19/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 46888 Based on interview, and record review, the facility failed to ensure Resident #2's change of condition (nose bleed) was properly assessed and documented across all shifts and failed to ensure physician orders were followed by not administering saline nasal spray at the prescribed time. The sample was six. The census was 79. Review of the facility's change in condition policy, dated 2/2012, showed: -Policy: It is the policy that resident change in condition will be assessed promptly and follow up activity will occur as appropriate and in a timely manner; -Definition: Change of condition is defined as an improvement or decline in the resident's physical, mental, or psychosocial status that effects less than two areas of activities of daily living; -Procedure: The staff person who first notices the change reports the resident change in condition immediately to the licensed nurse. The licensed nurse assesses the resident including vital signs and notes signs and symptoms, regarding physical and mental changes in condition. The results of the assessment, including the vital signs, signs, symptoms and any physical and/or mental changes in condition are documented in the resident's medical record. The resident's primary physician or designated alternate will be notified immediately of any change in resident's physical or medical condition, this includes: Deterioration in health, mental, or psychosocial status or 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). The resident's designated medical contact or guardian will also be notified. Nursing judgment should be used given the time of day and the severity of the resident change. 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. It is the responsibility of the nursing staff to inform the resident's medical contact of any change of condition. 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 Resident #2's record showed: -Diagnoses included hypertension, diabetes, and major depressive disorder; (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Moderately impaired cognition. Review of the resident's care plan, in use at the time of the investigation, showed: -Problem: Resident is at risk for hemorrhage (bleeding) due to receiving anticoagulant (AC) medication for history of stroke with cognitive deficits; -Goal: Resident will maintain cognitive abilities by making needs known through next review date; -Approach: See orders for current medication regimen. Document and notify the provider, family/responsible party for changes as needed. Observe for changes in condition such as black tarry stool, bruising, hematuria (blood in the urine), nose bleeds. Observe for conditions or medications which could enhance or inhibit anticoagulation such as thyroid medications or other anticoagulant. Pharmacy review of medications monthly or per facility protocol and PRN (as needed). Protect from falls and injury as much as possible. Review of the resident's physician's orders sheet (POS) included: -An order, dated 1/4/25, for Aspirin (anti-inflammatory that also is an anti-coagulant) 325 milligram (mg) once per day; -An order, dated 1/4/25, for Clopidogrel (Plavix, anticoagulant) 75 mg once per day; -An order,dated 2/7/25, for saline nose spray to be given at 9 A.M., 12:00 P.M., and 9:00 P.M. Review on 2/11/25, of the resident's progress notes showed: -A progress note, from 2/7/25 at 12:35 P.M.,written by Licensed Practical Nurse (LPN) C, resident had nose bleed. He/She has tissue in his/her nose. Advised resident not to put anything in his/her nostrils. Cold compress place on bridge of nose and asked him/her to put pressure on it and hold head forward. Heat in room also turned down. Explained that the dry heat can cause the membrane to dry out and can cause nose bleeds. After 10 minutes bleeding has stopped. He/She did ask where he/she could get a humidifier and LPN C explained to the resident to ask his/her sister if she can get him/her a small one; -A progress note from 2/7/25 at 5:43 P.M., written by LPN C, the resident requested to go to the hospital; says his/her nose keeps bleeding. The nurse called the physician's exchange; -A progress note from 2/7/25 at 6:17 P.M., written by LPN C, the physician ordered saline nose spray three times a day and to hold Plavix 75 mg and aspirin 325 for two days, restart medications on 2/10/25; -No notes during the 7 PM to 7 AM shift on 2/7/25 to 2/8/25; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A progress note from 2/8/25 at 8:00 A.M., written by LPN A, staff found the resident with blood on his/her face. Dried blood was visible on the bed. The resident's nose was still bleeding slightly. petroleum jelly and a 4x4 (gauze) was applied inside the nostril. Vital signs taken: Blood pressure 90/62 (normal 120/80), pulse 56 (normal 60-100), respirations 18 (normal 12-20), temperature 96.5 (normal 98.6) degrees Fahrenheit (F). Physician called and made aware, order given to send resident out to the hospital for evaluation and treatment; -A progress note from 2/8/25 at 8:09 A.M., written by LPN A, the nurse called an ambulance for transport to the hospital. The resident was in the wheelchair and responsive; -A progress note from 2/8/25 at 8:17 A.M., written by LPN A, this writer notified per Certified Nursing Assistant (CNA) that resident had attempted to get back into bed, but only his/her upper half was in the bed. This writer went back into resident's room, resident's body completely in bed. While this writer was speaking with the resident, he/she began turning from side to side in bed. The resident's skin was clammy and resident was lethargic but continued to respond when name was called. 911 called and LPN A and Certified Medication Technician (CMT) B at the resident's bedside until Emergency Medical Services (EMS) arrived. Review on 2/11/25, of the resident's February Medication Administration Record (MAR) showed: -Saline nasal spray not listed on the MAR; -No documentation to show staff administered the saline nasal spray. During an interview on 2/11/25 at 12:22 P.M., LPN C said on 2/7/25 around 12:35 P.M., the resident came to the nurse's station and said his/her nose was bleeding. He/She gave the resident a cold compress and observed that the resident had placed tissue in his/her nose. LPN C explained to the resident why he/she should not do that. He/She then turned the resident's heat down in the room The nosebleed stopped after around 10 minutes. The resident then came back around 5:45 P.M. and said that he/she wanted to go to the hospital because his/her nose was still bleeding. LPN C called the resident's responsible party who at first said they would take the resident to the hospital but then decided not to. He/She also contacted the resident's physician to inform them of the resident's nose bleed, that the resident was putting tissue in his/her nose, and the resident's request to go to the hospital. The physician called around 6:00 P.M., and told him/her to not administer the resident's AC medication until 2/10/25 and ordered nasal saline solution to be given three times a day. The physician did not give an order to send the resident out to the hospital. LPN C then called the resident's responsible party to give him/her updates. The CMT administered the nasal saline solution to the resident after it was ordered. LPN C did not complete a change in condition assessment. When he/she left around 7 P.M., the resident was alert. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/14/25 at 7:13 A.M., LPN E said he/she was told by the day shift nurse that the resident was having on and off nose bleeds and that the physician ordered saline solution and to hold the resident's AC medication until 2/10/25. He/She did see a few drops of blood on the floor leading to the resident's bathroom during his/her shift. He/She thought the blood was from the day shift nose bleed. He/She also saw blood on the resident's pillow the size of a golf ball and two golf ball sized spots of blood on the resident's fitted sheet. Two hour checks were performed on the resident, and the resident slept all night and did not get up or report another nose bleed. LPN E conducted rounds on the resident around 4:00 A.M. and did not see the resident having a bloody nose. CNA F never reported any issues with the resident to him/her. LPN E did not witness the resident bleeding. LPN E did not administer the resident's nasal saline solution. LPN E did not document anything in the chart for the resident during his/her (7 P.M. to 7 A.M.) shift on 2/7/25 to 2/8/25. During an interview on 2/14/25 at 12:07 P.M., CNA F said he/she worked the 7:00 P.M. to 7:00 A.M. shift on 2/7/25 to 2/8/25. He/She was told that the resident had a nose bleed earlier in the day but was not given any further instructions. The resident is independent with care needs, so he/she does not need to provide the resident a lot of care on his/her night shifts. CNA F did not witness the resident having a bloody nose. CNA F was not sure if he/she saw blood in the resident's room. During an interview on 2/11/25 at 9:52 A.M., LPN A said on the morning of 2/8/25, he/she went to the resident's room to tell him/her it was time for breakfast. The resident said he/she did not feel well. LPN A turned on the resident's lights and saw that the resident had blood on his/her pillow and bed sheet. The resident said his/her nose had been bleeding on and off since the day before. LPN A transferred the resident to his/her wheelchair from the bed. He/She packed the resident's nose with gauze and petroleum jelly. He/She called the physician who said to send the resident out to the hospital non-emergent. He/She went to perform other tasks and was then told by the CNA that the resident was not doing good. LPN A went back to resident's room. The resident had tried to transfer himself/herself back into bed and was holding onto the side of the bed. The resident's skin was clammy, and the resident was lethargic. LPN A called 911 for emergent transport to the hospital. The resident did not report any swallowing of blood to him/her. LPN A said this would have been a huge cause for concern and he/she would have called the doctor and sent the resident to the hospital 911 if he/she had been swallowing blood. LPN A said staff conduct rounds on residents every two hours. He/She was told by the overnight nurse that there was an order to hold the resident's AC medication and to administer nasal saline spray three times a day. He/She would expect all changes in condition to be reported to the Director of Nursing (DON), physician, and the resident's responsible party. During an interview on 2/11/25 at 11:29 A.M., CMT B said he/she was working on 2/8/25 on the resident's assignment. He/She assisted the nurse in getting the resident's vital signs. He/She stayed with the resident while the nurse called 911. The resident was alert but just barely. The resident was lying in bed and appeared uncomfortable. Right around the time EMS arrived, the resident's eyes became fixed. The resident's nose was bleeding a small amount. There was not a lot of blood in the resident's room or on the resident. On the resident's pillow there was a golf ball size amount of blood and two golf ball sized amounts of blood on the resident's fitted sheet. There were a few drops of blood leading to the resident's bathroom. CMT B did not witness the resident swallowing or spitting up blood. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/14/25 at 1:35 P.M., the Physician said she feels that the facility did their due diligence with the resident. She was contacted four times with updates on the resident's nose bleeds. She said if the nose bleed had been posterior, the resident would have been spitting up blood, and that was not reported to her. During an interview on 2/18/25 at 12:30 P.M., the Assistant Director of Nursing (ADON) and Administrator said they do not consider a nose bleed to be a change in condition. They would not have expected staff to complete a change in condition assessment. They said the resident was on blood thinners and was care planned to watch for nose bleeds. They both believed the nose bleed to be a side effect of the resident's AC medication. They would expect all nursing staff to document any care given to residents or changes in condition during their shifts. MO00249241