STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265672	A. Building B. Wing	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Wellness Center	3421 Gasconade Saint Louis, MO 63118

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review, the facility failed to provide a homelike environment by not providing an adequate supply of linens for resident care. In addition, the first-floor dining room had areas with baseboards missing, creating holes in the wall. The census was 74.Review of the facility's Residents Rights policy last revised August 2020, showed, the facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment, that promotes maintenance or enhancement of his or her quality of life. 1. Observation on 6/8/26 at 5:30 A.M., of the second-floor linen room showed two blankets and no other linen. The linen cart had one fitted bed sheet and two towels. Observation on 6/12/26 at 7:28 A.M., showed:-The first-floor linen room had 7 washcloths, 4 bath towels and no bed linens;-The first-floor linen cart on the had no washcloths, towels or bed linens;-The second-floor linen room had no washcloths, 4 bath towels, and no bed linens;-The second-floor linen cart had two fitted bed sheets. During an interview on 6/11/26 at 1:30 P.M., Laundry Aide (LA) J said he/she washes the laundry as they come down the laundry chute and then restock the linen closets. There is no extra linen in the laundry room. Everything is sent to the floor when it is washed. The staff will sometimes come down and look for linens, but it is still in the washer or dryer. Observation at this time showed the laundry room had linens in the dryer and no linens on any shelving storage units or tables in the laundry room. During an interview on 6/8/26 at 5:35 A.M., Certified Nursing Assistant (CNA) I said there are never enough linen to provide care to the residents. CNA I cannot provide proper personal care when there are no towels or washcloths. The resident bed sheets do not get changed due to the lack of bed linens. The lack of linens has been going on for several months. During an interview on 6/8/26 at 6:05 A.M., CNA H said on a Monday after the weekend there were no supplies which included incontinent pads for the beds. CNA H had to lay down towels on the bed instead of incontinent pads. CNA H could not perform personal care the correct way without the proper linens. CNA H only had one towel available for personal care. During an interview on 6/11/26 at 1:55 P.M., the Housekeeping Supervisor said she orders linens but believes that staff throw the linens away. There is no extra supply of linens in the laundry room for the staff to take if they run out of linen on the hall. During an interview on 6/12/26 at 2:06 P.M., the Administrator said he approves any linens that are ordered and was not aware that staff were having issues with not having enough linen to provide care. He would expect staff to have enough lines to provide care to the residents. 2. Observation of the first-floor main dining room, on all the days of survey from 6/8/26 through 6/12/26, showed the baseboard missing from various sections of the wall. Holes in the wall visible in the areas with missing baseboards. During an interview on 6/11/26 at 2:08 P.M., Licensed Practical Nurse (LPN) C said the contractors removed the baseboards a few weeks ago. The facility is in different stages of updating. Several residents eat in the dining room for meals. During an interview on 6/12/26 at 8:35 A.M., Resident #40 said workers removed the dining room baseboards a few weeks ago. The walls appeared rough and the holes behind the baseboards appeared dirty. He/She hoped the dining room would look better soon. He/She ate all meals in the dining room. During an interview on 6/12/26 at 2:05 P.M., the Administrator said the first-floor main dining room baseboards were removed a week ago. He did not know when the (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	baseboards would be replaced. The dining room did not appear homelike, and the facility was in various stages of remodeling and repair. He communicates weekly with corporate management regarding the facility remodeling. 2717445

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide adequate treatment and services for two residents with pressure ulcers (wounds related to prolonged pressure on bony prominences) (Resident #1 and #5) and interventions to prevent pressure ulcers for one resident (Resident #1). The facility failed to provide treatments as ordered and change dressings when saturated, (Residents #1 and #5). The facility also failed to provide Residents #1 with a low air loss mattress (LAL, special mattress that reduces pressure and moisture to prevent wounds) set to the correct settings and pressure-reducing devices, per the care plan. Staff did not lay Resident #5 in bed between meals, as recommended by the Wound Physician and Director of Nursing. Resident #1 and Resident #5 both experienced worsening pressure ulcers. The sample size was 21. The census was 74. Review of the facility's Wound Management policy, dated 06/2020, showed: - To provide a system for the treatment and management of residents with wounds including pressure and non-pressure injury;- Pressure injury/pressure ulcer (PI/PU)- any lesion caused by unrelieved pressure that results in damage to the underlying tissue. Although friction and shear are not primary causes of pressure injury, friction and shear are important contributing factors to the development of pressure injuries. Pressure injuries usually occur over bony prominences (elbows, heels, hips, sacrum (middle portion of the lower back)/coccyx (tailbone)) and are graded or staged to classify the degree of tissue damage observed;-The Attending Physician will be notified to advise on appropriate treatment promptly;-The Licensed Nurse (Licensed Practical Nursing (LPN), Registered Nurse (RN), Assistant/Director of Nursing (ADON/DON) will notify the party responsible of the presence of a pressure injury;- Per Attending Physician order, the Nursing Staff will initiate treatment and utilize interventions for pressure redistribution and wound management;- Update the resident's care plan as necessary. 1.Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 05/08/26, showed:-Severely impaired cognition;-Resident's weight was 136 pounds (lbs.);-Fully dependent on two-person assistance for activities of daily living (ADLs), personal hygiene and mobility.;Diagnoses: Hepatitis C (bloodborne pathogen that affects the liver inflammation (swelling), sepsis (bacterial infection in the blood), Stage 4 pressure ulcer (full-thickness tissue loss with exposed bone, tendon, or muscle), lack of coordination and severe protein-calorie malnutrition (inability to keep nutritional balance);-Frequently incontinent of bowel and bladder;-Number of stage 3 PU/PI (full-thickness skin loss with visible fat but no bone/tendon exposure) total of two;-Number of stage 4 PU/PI, total of one;-Number of stage unstageable PU/PI (wound covered by slough/eschar so depth cannot be determined) total of one.-Pressure reducing device for chair/bed;-Pressure ulcer/injury care. Review of the resident's care plan, last updated 03/17/26, showed:-Focus: Has a pressure ulcer to his/her sacrum and bilateral lower legs;Desired outcome: Will have no complications related to pressures ulcer to sacrum;Interventions: Educate resident/family/caregivers of causative factors and measures to prevent skin injury, encourage nutrition and hydration, follow facility protocols and treatments (Txs) intravenous (IV) infusions to promote wound and hydration, keep skin clean and dry, resident needs pressure relieving/reducing mattress to protect the skin while in bed, monitor/document location, size and Txs of skin injury, report abnormalities failure to heal, signs and symptoms (s/sx) of infection, maceration (soft tissue breaks down after prolonged exposure to moisture) to medical doctor (MD);-Focus: Resident has open area to his/her left knee and sacral area upon admission. On 10/03/25, open area to left lateral ankle;-Goal: Wound will be free of s/sx of infection(s);-Interventions: Apply low air loss mattress, monitor mattress for right settings, apply orthotic suspension boots (green protective boots elevates the heels off the mattress), educate staff on LAL mattress settings, provide wound care per Tx orders;-Focus: Has ADL self-care performance deficits related to mobility, stroke;-Desired outcome: Will maintain current level of (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	function;-Interventions: The resident is bedfast most of the time, two-person assist with transfers, repositioning and turning. Resident requires skin inspections daily. Review of the electronic physician's order sheet (ePOS), dated 4/20/2026, showed: -An order, dated 06/04/26, showed: May use low air loss mattress. Check setting every shift to ensure setting are within therapeutic range;-LAL mattress orders did not specify a therapeutic range which would be set to the resident's weight; -An order, dated 06/04/26, showed: Right buttocks-clean with normal saline (NS) (sterile water), apply Dakins 0.125% (antiseptic solution used to treat infected wounds) moistened gauze, and cover with bordered foam dressing (drsg), change daily and as needed (PRN),-An order date 06/04/26, showed: Right Anterior (front) Knee- Clean with NS, apply calcium alginate (CA+ Ag) (seaweed-based dressing for moderate-to-heavy wound drainage) and dry dressing (DD) daily and as needed (PRN); -An order, dated 06/04/26, showed: Left Lateral Hip- Clean with normal saline, apply calcium alginate, cover with bordered foam dressing (drsg). Change daily and PRN;-An order, dated 06/05/26, showed: Left lateral 5th toe wound- Clean with normal saline, apply calcium alginate, daily and PRN. Change daily and PRN;-An order date 06/05/26, showed: Right Thumb wound- Clean with normal saline, apply calcium alginate, cover with dry drsg. Review of the Vendor 1's operations manual for the LAL system, undated, showed:-Indications: Pump and mattress system, is indicated for the prevention and treatment of any and all stage pressure ulcers when used in conjunction with a comprehensive pressure ulcer management program. It can be used in a hospital, homecare, or other healthcare environment;-Operating instructions: Determine the patient's weight and set the control knob to that weight setting on the control unit. Review of the Wound Doctor's progress note, dated 01/08/26, showed a midline sacrum wound measured 11.0 centimeters (cm) in length (L) by 9.0 cm width (W) by 2.50 cm depth (D), Stage 4 PI/PU with undermining (tunneling pocket created under the skin) from 3 o'clock to 6 o'clock (location of the tunneling). Wound noted as improved. Review of the Wound Doctors progress note, dated 02/26/26, showed:-Left lateral hip PI/PU unstageable measurements; Length was 4.0 cm by width 8.0 cm. by depth 0.10 cm, total area 32.00 cm.;-Midline sacrum stage 4 PI/PU measured L 7.0 cm. by W 10.0 cm. by 2.50 cm, total area 70.00 cm. Tunneling from 1 o'clock to 6 o'clock, 5 cm., wound status stable. Review of the Wound Doctor's progress note, dated 03/26/26, showed:-Left lateral hip PI/PU Stage 3 measurements Length was 3.0 cm by width 8.0 cm. by depth 0.10, total area 24.00 cm. subsequent - improved, no drainage;-Midline sacrum stage 4 PI/PU measured L 10.0 cm. by W 11.50 cm. by 2.00 cm area 115.00 cm. tunneling from 11 o'clock to 6 o'clock, 5 cm., wound status stable, moderate drainage. Review of a nurse's progress note, dated 03/31/26 at 8:54 A.M., will continue to cleanse sacrum with wound cleanser/normal saline, apply Vashe (wound cleansing solution) soaked gauze, wet to dry dressing daily, until wound vac (applies controlled suction to a wound to accelerate healing) arrives, daily and PRN, every day shift until wound vac in place. Review of the Wound Doctor's progress note, dated 04/09/26, showed:-Midline sacrum stage 4 PI/PU measured L 12.0 cm. by W 13.00 cm. by 2.00 cm, total area 156.00 cm. Tunneling from 11 o'clock to 6 o'clock, 5 cm., wound status worsened. Moderate drainage;-Left lateral hip PI/PU stage 3 measurements Length was 3.0 cm by width 8.0 cm. by depth 0.10, total area 24.00 cm., stable;-New wound: Right knee abrasion (scrape, non PI/PU) stage 4, measurements L 1.00 cm by W 2.00 cm by D 0.10 cm, total area 2.00 cm., worsened. Review of the Wound Doctor's progress note, dated 04/09/26, showed:-Stage 3 PI/PU, right thumb, measured L 4.0 cm by W 5.0 cm D 0.10 cm, total area 20.0 cm, reopened; -Left lateral hip PI/PU stage 3 measurements, Length was 4.0 cm by width 8.0 cm. by depth 0.10, total area 28.00 cm., stable;-New wound: Right upper back PI/PU unstageable, measurements L 1.50 cm by W 2.50 cm by D 0.10 cm, total area 3.75 cm.; -New wound: Right buttock PI/PU unstageable, L 2.00 cm by 3.50 cm by D 0.10, total area 7.0 cm;-Midline sacrum, Stage 4 PI/PU, measured L 10.0 cm. by W 11.50 cm. by 2.00 cm, total area 115.00 cm. Tunneling from 11 o'clock to 6 o'clock, 5 cm., wound status stable, moderate drainage;-Right knee PI/PU Stage 4, measurements L 1.50 cm by W 2.00 cm by D 0.10 cm, total area 3.00 cm., worsened. Review of the Wound Doctor's progress note dated 05/11/2026 at 08:11 A.M., showed:-On 01/29/26: Wound stable, (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	still need to work on optimizing offloading;-On 02/26/26: new left hip wound, possible from resident laid on tube feeding (TF) tube;-On 03/26/26: Wounds overall stable. Will reattempt wound vac on sacrum;-On4/9/26: Wound vac seems to be working well. Patient with several new wounds today, will address with DON; -On 4/16/26: Delay in wound vac supplies, will cover with moistened Dakin's gauze right now;-On 4/30/26: For unclear reasons, a wound vac has not appeared. Today there appears to be a continued decline in overall patient status, with most wounds worsened. This likely represents a deterioration of patient status. Based on the appearance of the sacral wound, which was not debrided (removal of dead tissue from a wound) as the extent exceeds what is capable at the bedside, the wound physician recommend transfer to the Emergency department (ED) for initiation of IV antibiotics, operative surgical debridement, and further assessment for this decline in patient. Family may also want to revisit hospice care; -On 05/07/26: Pt has returned from the hospital. Wounds stable to improved. Review of the hospital discharge after visit summary (AVS) dated 05/05/26 at 03:02 P.M., showed (page 9), wound care instruction: -Right ischium (lower and back part of the hip bone), right upper back, right knee, left hip: Wash wound with soap and water. Pat dry, apply silver stat gel (used for wound healing) to wound bed and top with foam dressing. Change Mondays, Wednewdays, Fridays;-Sacrum: Wash wound with Vashe Cleanse (directions below). Lightly pack Vashe soaked wet to moist kerlix (type of gauze) into wound bed, top with ABD (highly absorbent) bandage, and secure with Medipore tape (breathable, surgical tape). Change twice daily (BID);-Left Ischium: Wash wound with Vashe cleanse. Lightly pack Vashe soaked wet to moist kerlix into wound bed and top with foam dressing. Change BID;-Reduce friction/shear- lift patient in bed with sheets or pad. Do Not Pull or Drag, Single layer flat sheet for turning/microturns if glide sheet is not available. Review of the resident's Medications/Treatment Administration Record (MAR/TAR) dated May 2026 showed:-An order date of 05/06/2026-05/08/2026, cleanse sacrum with Vashe cleanser, lightly pack Vashe soaked gauze/kerlix into wound bed, top with ABD pad and secure with medipore tape change BID at 08:00 and 04:00 P.M.;-Treatments missed three out of six opportunities; -An order dated 05/06/2026 through 05/11/2026, showed Left ischium: Wash wound with Vashe cleanser. Lightly pack Vashe soaked wet to moist kerlix into wound bed and top with foam dressing. Change BID at 08:00 A.M., and 4 P.M.;-Treatments missed two out of 21 opportunities. Review of the Wound Doctor's progress note dated 05/28/2026 at 12:54 P.M., showed:-On 5/14/26: Right buttock wound unroofed (surgically removing the top) today and extensively debrided, now a stage 3 pressure wound. Worrisome for potential progression to communicate with sacral wound. Will ask facility to evaluate nutrition status, and would recommend continued antibiotic coverage at this time;-On 5/28/26: Extensive debridement undertaken again today of right buttock wound. Culture obtained. Wound has precipitously worsened, and per staff, resident's human immunodeficiency virus (HIV) medication has been changed. His/Her current immune status is unclear, and he/she is either on or just completed prolonged antibiotic therapy. Will also check albumin (lab draw to check protein levels). Encourage family to consider hospice in the setting of our current decline. Review of the hospital discharge AVS dated 06/04/26 at 12:09 P.M., showed page 9, wound care instruction: -Left hip, right buttock and sacral wound dressings - 1/4 strength Dakin's (antiseptic wound cleanser) moist kerlix gauze placed inside the wounds, cover with ABD, secure. Change BID and PRN when soiled;-Feet, right back and knee wounds - clean with NS, dry, apply Mepilex foam (dressing that creates a moist, healing environment), change on Tuesday and Friday and PRN when soiled. Observation of the resident on 06/08/26 at 5:54 A.M., showed no green protective boots on his/her bilateral (both sides) extremities. Observation on 06/08/26 at 10:22 A.M., showed the dressing on the resident's right (R) knee, dated 6/7/26, was soiled with drainage on the back side of bandage. The dressing on the resident's left (L) iliac crest (hip bone) had pink drainage that bled through the bandage. During an interview on 06/08/26 at 10:22 A.M., LPN T said he/she could not read or find the date that the iliac crest dressing was last changed. Observation on 06/08/26 at 10:37 A.M., showed the resident lay on a folded blanket, a linen pad (absorbent pad) and a depends (brief, an adult absorbent garment). Certified (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Nurse Assistant (CNA) G lifted the gown and the gauze around the g-tube (a surgical site used for tube feeding/nutrients) site had the right top corner folded in on itself and stuck to the resident's gown. The LAL mattress pressure was set on 120 lbs. Observation on 06/08/26 at 10:50 A.M., showed on the resident's R knee non-PI/PU, the Wound Nurse used wound cleanser (antiseptic spray), patted the site dry, changed gloves and used Ca+ Ag, dug into the closet and then applied pink border drsg with the same gloves. For the resident's right thumb, the Wound Nurse applied CA+ Ag without (w/o) a bandage, however the site was covered with white gauze dressing. The wound bed was macerated with a pink bed and no drainage noted. The resident's left hip had a dressing with an illegible date. There was serosanguinous (combination of clear and bloody fluid) drainage at 12 o'clock to about 1' o'clock, approximately 1-inch (in) long, and the wound bed was oval in shape. The Wound Nurse used wound cleanser, packed the wound with Ca+ Ag and covered it with an Island (sterile long bandage) drsg. On the left outer lateral side below the smallest toe, the bandage was dated 6/7 and had no drainage. Between 5 o'clock and 7 o'clock there was necrotic (dead, non-viable tissue) or deep tissue injury (DTI) (bruised tissue unable to determine the underlying damage) which was discolored from the normal pigmentation of the resident. The wound was covered with Ca+ Ag and from 9 o'clock to 1 o'clock, there were small amounts of sanguineous (fresh blood) drainage. On the resident's right hip, the current bandage from 9 o'clock to 11 o'clock, showed drainage throughout the bandage. The Wound Nurse used Dakins solution and a mepilex drsg. The last wound was on his/her posterior (back) lateral right side and had a drsg dated 6/7. At the 12 o'clock area on the wound, on the outside of the dressing, there was noticeable serosanguineous drainage on oval shaped wound. The Wound Nurse and CNA G rolled the resident on a folded blanket, linen pad and brief. Staff turned the resident on his/her left side supine (back flat) and knee turned to the left side. The resident's g-tube dressing was not changed. During an interview on 06/08/26 at 10:50 A.M., the Wound Nurse said all of the resident's wounds were related to pressure, aside from the right thumb that was non-pressure. The Wound Nurse said the resident's right thumb should have bandage around the wound; however, she only uses a gauze to wrap it. Observation on 06/09/26 06:37 A.M., showed the LAL mattress was set at 120 lbs. The resident had a folded blanket, linen pad and brief under him/her. On resident's right hip, there was a bandage, covered in drainage, dated 6/8, by the Wound Nurse. Observation on 06/09/26 6:47 A.M., showed the resident lay in bed and had one green protective boot on. The other boot lay on the floor next to the window. The LAL bed set was set at 130 lbs. Observation on 06/09/26 11:58 A.M., the resident had one green protective boot on the foot and the other boot was on the floor. The resident lay on his/her right side, knees facing the wall/window, with a folded blanket, linen pad and brief directly under the resident. The resident's left lateral foot wound drsg was dated 6/9. Observation on 06/11/26 10:37 A.M., showed the resident had one green protective boot on and the other boot was on the floor. The LAL setting was set at 160 lbs. The resident lay on a folded blanket, chux pad (disposable underpad) and brief in bed. Observation on 06/12/26 8:55 A.M., showed the resident in bed with the LAL mattress set at 160 lbs. The resident's right knee had an island drsg with brownish-red drainage at the top right corner. During an interview on 06/08/26 at 2:26 P.M., CNA Q said offloading meant to reposition the resident every (q) two hours (hrs) with the following equipment that can be found in house: Wedges (a foam triangle that keeps the resident on their side), green protective boot, pillows. These were all in house, and the resident needed to have an order. CNA Q said the setting on the LAL mattress meant air went into the mattress, however, he/she did not know the appropriate setting for this particular resident. Every resident was different. An example was given of, if a resident was 200 lbs and the setting was set at 150 lbs or 350 lbs, how would you know if these settings were appropriate/inappropriate? CNA Q said he/she would need to ask the nurse. CNA Q said their common practice was to place a folded blanket, linen pad and a brief on residents. Some places allow the resident to have a brief on residents with wounds and LAL mattresses, and we follow facility policies. During an interview on 06/08/26 at 4:18 P.M., LPN C said the resident always had one wound on his/her sacrum/coccyx but somewhere (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	between February and April of this year, he/she started to develop more. The resident used to be on a wound vac, but the resident moved, which cause the wound vac to malfunction. There were no concerns he/she knew of related to supplies from the wound vac being delayed or not available. LPN C said offloading meant to move the resident off the side that has pressure by pillows, wedges or green protective boots. LPN C was not sure of what the LAL setting should be on, but the setting makes the mattress firmer or softer. LPN C was not familiar with the current settings or what they meant. It is standard practice for a folded blanket, linen/chuck pad and brief to be under the resident. The facility protocol prefers briefs worn. If there was drainage coming through the bandage, he/she would notify the provider, which is the Wound Doctor and change the dressing as much as possible, if the bandage is soiled. During an interview on 06/11/26 at 10:37 A.M., LPN B said the resident should have bilateral boots on, especially since the left foot has pressure on it from being turned to his/her left side. During an interview on 06/08/26 at 4:38 P.M., the Wound Nurse said there was a single wound in/around January of this year, then more wounds started to develop. The wound vac started to detach from the site because the resident had liquid bowel movement (BMs) that loosened up the seal around the wound. The Wound Nurse did not recall what interventions were established or if the facility attempted a fecal matter system (FMS) (a temporary tube in the rectum to catch liquid stool) and medications to harden the BMs. The second time the facility attempted to use a wound vac was in April. The Wound Nurse was not aware of delays in supplies for the wound vac. The second time the wound vac was used, the original delivery did not come with enough supplies to maintain the wound changes because the wound vac did not have a good enough seal. At one point, the wounds had improved then rapidly deteriorated. After the second failure of the wound vac, the new orders were to use Dakin's solution. The Wound Nurse said offloading meant keeping the resident off the pressure areas - wedges, pillows, protective boots, hand-splints, washcloth for the hand. An LAL mattress helps with firmness. We had to reeducate CNAs to keep it at the right setting, because it helps regulate pressure on those areas, and settings are based on the resident's weight. It is not common practice to use the fold blanket, linen/chuck or brief. The Wound Nurse thought staff should use just a sheet and chuck or brief. A brief is a counterindication when you have a wound on the sacrum/coccyx because human waste breaks the skin down more and can infect the wound. When a resident returns from the hospital, the nurse contacts the MD and reads the orders, then the MD will enter the order if the MD agrees or continues with same tx before the hospital. The Wound Nurse reviewed the patient's discharged hospital records from 05/31/26-06/04/26 on page 9 and said these are definitely orders. The nurse who accepted the resident should review the paperwork to put the orders in, then wound nurse or DON would look over the paperwork. During an interview on 06/11/26 at 11:27 A.M., the Wound Doctor said offloading meant to elevate the patient to a 30-degree side-lying position with right/left side rotation, without continuous pressure where wounds are located. He would expect pillows, wedges and boot protectors to be used. He would expect a boot on the left foot of the resident if laying on the left side. setting is based on weight. The Wound Doctor was not sure how LAL orders work, but the setting is based on the resident's weight. He normally does not add a numeric number for the setting, however, he could modify that order. The LAL purpose was to alternate the pressure when lying down, evenly when static position. The Wound Doctor said he expected a sheet and chuck and brief to be on the bed to eliminate pressure on the resident. He was not sure if there was ordering and supply issues in April, and he was not sure why the wound fact failed. They could not get a great seal. Wound Doctor would not expect staff to reach out to the medical doctor/house doctor for new interventions, but it made reasonable sense new interventions could be in place. Wound Doctor was not made aware of any new recommendations from the hospital related to the resident's stay between 05/31/26 and 06/04/2026. Wound Doctor would expect staff to contact him within 48 hours to discuss new orders. He expected wound dressings to be changed when the dressing was soiled, or when the drainage leaked through the dressing. Even if the dressing was just changed, the purpose of the PRN order was to keep wound dry and clean. During an interview on (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Wellness Center	3421 Gasconade Saint Louis, MO 63118

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F 0686 Level of Harm - Actual harm Residents Affected - Few	06/12/26 at 02:01 P.M., the DON said she would expect nurses to put in a note related to the wounds anytime a change is noted. The DON expected nurses to contact the wound doctor about any recommendations and execute those orders. It is expected that staff turn the residents frequently. DON said offloading meant to turn frequently and to keep the resident from continuous pressure, which can be done by turning to side and back with pillows, wedges, and boots for heel protection. She would expect staff to check LAL for the correct weight setting; settings should always reflect the current weight of the resident. She expected the current weight to match the setting. The Wound Nurse educates the staff. Residents should not have a sheet; there should only be a pad, although it is based on patient preference. The resident can have a brief on. The blanket is used as a draw sheet because you need some leverage to pull the patient up or for turns. The resident had a higher risk for breakdown. If a resident lays on a medical device like his/her TF tube, it can cause skin break down, and staff should monitor for that. 2.Review of Resident #5's medical record, showed:-re-admitted [DATE];-Diagnoses included dementia, high blood pressure, dysphagia (difficulty swallowing), diabetes and wounds. Review of the ePOS, showed:-An order, dated: 04/07/26: May use low air loss mattress, check settings every shift to ensure settings are within therapeutic range. Review of the physician wound visit notes, dated 4/9/26, showed:-A visit note, dated 04/09/26: -Wound 3: Bilateral midline sacrum; -Severity: Stage III; -Status: Worsening; -Size: 2.5 cm x 1.2 cm x 0.1 cm; -Wound base: 50% granulation and 50% dermis; -Periwound (area around the wound): Intact; -Exudate (drainage): Moderate; -Plan: Clean with NS, apply Calcium Alginate and bordered foam dressing. Change daily and PRN for dislodgement, saturation or soiling;-A visit note, dated 04/16/26: -Wound 3: Bilateral midline sacrum; -Severity: Stage III; -Status: Stable; -Size: 2.5 cm x 1.2 cm x 0.1 cm; -Wound base: 50% granulation and 50% dermis; -Periwound: Intact; -Exudate: Moderate; -Plan: Clean with NS, apply calcium alginate and bordered foam dressing, change daily and PRN if dislodged, saturated or soiled;-A visit note, dated 04/23/26: - Wound 3: Bilateral midline sacrum; -Severity: Stage III; -Status: Worsening; -Size: 5 cm x 2.5 cm x 0.1 cm; -Wound base: 50% granulation (healing tissue) and 50% slough (dead tissue); -Periwound: intact; -Exudate: Moderate -Procedure: debridement, new measurements: 5.0 cm x 2.5 cm x 0.2 cm; -Plan: clean NS, apply calcium alginate and bordered foam dressing, change daily and PRN if dislodged, saturated or soiled;-A wound visit note, dated 04/23/26: -Wound 3: bilateral midline sacrum; -Severity: Stage III; -Status: worsening; -Size: 5.0 cm x 2.5 cm x 0.1 cm; -Wound base: 50% granulation and 50% slough; -Periwound: Intact; -Exudate: Moderate; -Treatment: Clean with NS, apply calcium alginate and bordered foam dressing, change daily . Review of the quarterly MDS, dated [DATE], showed:-Unable to make needs and wants known;-Required full staff assistance for care and mobility;-Incontinent of bowel and bladder;-At risk to develop pressure injury;-Had two stage III pressure ulcers;-Pressure reducing device for chair and bed;-Received nutrition and hydration care for wounds;-Received ointments and medications other than to the feet. Review of the interdisciplinary team (IDT) wound review note, dated 04/29/26, showed:-Reviewed by the IDT for wound care management. Wounds noted to left hip and bilateral midline sacrum. The resident is total assist with all care, transfers and required full staff support for positioning and care. The resident speaks minimally and limited in voicing needs. The resident is seen by the wound care physician. Review of the progress note, showed a nurse's note, dated 05/04/26 at 9:42 A.M.: The resident's wounds noted to worsen related to comorbidities. He/She experienced malnutrition and preferred to lie on his/her left side. Review of the IDT nutritional progress note, dated 05/07/26, showed the resident received a regular diet with bite sized pieces. Supplements included house shake supplements, and vitamins. Staff provide feeding assistance and he/she eats in the dining room. The resident consumes 50-75 percent (%) of meals. Registered Dietician (RD) agreed interventions in place were appropriate. Review of the ePOS, showed:-An order, dated 05/07/26: House supplement four times a day for weight loss. -Review of the wound visit notes, showed:-On 05/07/26: -Prior note from 04/30/26: Continued deterioration, stressed the need to offload, but this is difficult due to patient inability to comply; -Wound 3: Bilateral midline sacrum; -Severity: Stage III; -Status: Stable; -Size: 5.0 (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	cm x 2.7 cm x 0.1 cm; -Wound base: 85% dermis and 15% slough; -Periwound: Intact; -Exudate: Moderate; -Procedure: Wound debridement and post measurement: 5 cm x 2.7 cm x 0.2 cm. -Treatment: Clean with NS, apply calcium alginate and bordered foam dressing, change daily and PRN if dressing becomes soiled, dislodged or saturated;-On 05/14/26: -Wound 3: Bilateral midline sacrum; -Severity: Stage III; -Status: Stable; -Size: 5 cm x 2.7 cm x 0.1 cm; -Wound base: 15% slough, 85% dermis; -Periwound: Intact; -Exudate: Moderate; -Procedure: Wound debridement and following wound measurement: 5 cm x 2.7 cm x 0.2 cm; -Treatment: Clean with NS, apply calcium alginate and bordered foam dressing, change daily and PRN if dressing becomes soiled, dislodged or saturated. Review of the progress notes, showed:-On 05/15/26 at 1:35 P.M., an IDT wound note: Reviewed for wound care management. The resident noted to have wounds to the left hip and bilateral midline sacrum. The resident is total assist with all care, transfers and required extensive staff assistance for positioning and care. Wounds are being monitored and treated per physician orders, wound care round weekly with the wound care physician, RD and wound care protocol. Sacral wound progressing. Interventions included low air loss mattress, skin assessments, dietary supplements to aide with wound healing, and wound dressings as ordered. Nursing to monitor for signs and symptoms of infection, delayed healing and overall decline. Review of the ePOS, showed:-An order, dated 05/19/26: clean left hip with wound cleanser (WC), cover with calcium alginate and dry dressing. Change daily until healed;-An order, dated 05/19/26: clean sacrum with WC, apply xerofoam (gauze dressing used to keep the wound moist) and cover with a dry dressing. Change daily until healed. Review of the Wound Physician notes, showed:-On 5/28/26: -Wound 3: Bilateral midline sacrum; -Severity: Stage III; -Status: Stable; -Size: 5 cm x 2.8 cm x 0.1 cm; -Wound base: 80% granulation, 20% slough; -Periwound: Intact; -Exudate: Moderate; -Procedure: Wound debridement and following wound measurement: 5 cm x 2.8 cm x 0.2 cm; -Treatment: Clean with NS, apply Triad cream (zinc oxide-based, moisture-absorbing paste primarily used for managing wounds with light to moderate drainage) and leave open to air. Change daily and PRN if dressing becomes soiled, dislodged or saturated;-On 06/02/26: - Wound 3: Bilateral midline sacrum; -Severity: Stage III; -Status: Stable; -Size: 5 cm x 3 cm x 0.1 cm; -Wound base: 80% granulation, 20% slough; -Periwound: Intact; -Exudate: Moderate; -Procedure: Wound debridement and following wound measurement: 5 cm x 2.8 cm x 0.2 cm; -Treatment: clean with NS, apply Triad and leave open to air. Change daily and PRN if dressing becomes soiled, dislodged or saturated. Review of the care plan, revised 06/08/26, showed:-Focus: Wound care needs related to pressure injuries to the left hip and sacrum;-Goal: Wounds will show signs of healing;-Interventions: Staff identify causative factors and eliminate, resolve when possible, inform staff of causative factors and measures to prevent skin breakdown, low air loss mattress and monitor/document the location, size and treatment of pressure injuries. Report abnormalities, failure to heal and signs of infection to the physician. Observation and interview on 06/08/26 at 6:09 A.M., during a skin assessment, showed the resident's left hip with a bordered, undated treatment. CNA V rolled the resident onto his/her left side and exposed the coccyx. The resident's brief noted to have yellow with light green drainage from the sacral wound. The wound was uncovered and approximately 3cm in area. There was necrotic tissue in 75% of the wound bed, and the tissue around the wound was red and inflamed. CNA V said he/she changed the resident once during the night shift and the sacral wound was uncovered. The resident is very thin. The resident has wounds to his/her left hip and his/her sacrum, and both should be covered. Observation and interview on 06/09

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F 0689 Level of Harm - Actual harm 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** Based on observation, interview and record review, the facility failed to ensure resident safety and protective oversight. During a staff-assisted transfer from a wheelchair to a bed, one resident's (Resident #16) foot became entangled in the wheelchair wheel, resulting in a femur fracture requiring hospitalization and surgical repair. In addition, the facility failed to follow its mechanical lift policy during a resident transfer (Resident #69) and failed to ensure safe smoking practices for residents who smoked (Residents #32, #66 and #71) and follow the smoking policy and schedule. The sample size was 21. The census was 74. Review of the gait belt policy, revised 6/2020, showed:-Purpose: To provide assistance to clinical staff when moving a resident from one place to another and to increase the safety of residents by allowing clinical staff members to grip it and keep the resident from falling.-Policy: A gait belt may be used for residents who are too weak to walk or stand alone, or required assistance during transfers;-Procedure:--Explain the purpose and procedure to the resident;--Place the gait belt around the resident's waist over the clothing with the buckle in front;--Secure the belt according to manufacturer's directions;--Ensure that the belt is snug, but allows for enough room to get two fingers between the belt and the resident;--If the resident begins to fall, pull the resident close and slowly lower the resident to the floor if unable to stabilize and call for assistance. Review of the total mechanical lift policy, revised 6/2020, showed:-Purpose: The mechanical lift is used appropriately to facilitate transfers of residents;-Policy:--Nursing staff will be trained to use the mechanical lift;--The resident will have a physician order for the use of a mechanical lift;--At least two people are present while resident is being transferred with the mechanical lift;-Procedure:--Place the sling under the resident, arrange the resident's arms so they are flat next to the body;--Position the lift under the resident's bed or around the chair;--Set base legs to the widest position under the resident and lock the wheels;--Lower the boom bar, and lower enough that the sling loops will reach the hooks;--Hook the loops on the side of the sling, and attach the sling to the correct hook on the bar;--Raise the boom bar on the lift;--Keep the resident centered between legs of the base and facing the person who is operating the lift;--Move the resident to the destination and lower into position. Review of the facility's Smoking by Residents policy, revised November 2023, showed:-Purpose: To respect resident choice to smoke and to maintain a safe and healthy environment for both smokers and non-smokers;-Policy: Smoking is no allowed anywhere inside the facility; The facility only permits smoking only in the area designated by the facility's safety committee; Resident who want to smoke will be assessed for their ability to smoke safely prior to being allowed to smoke independently in these areas; Residents who are not able to smoke independently and safely will be accompanied by facility staff while smoking; all smoking sessions will be supervised by the facility staff members; All smoking materials will be stored in a secure area to ensure they are kept safe; Residents are strongly encouraged not to share their smoking materials with any other residents, Smoking sessions are limited to 15 minutes. Review of the facility's Smoking Violation policy, undated, showed:-Smoking tobacco, matches, lighters, or other smoking paraphernalia cannot be kept by residents or stored in their rooms; Smoking by resident is only permitted in designated facility areas at designated times regulated by the facility; Smoking by resident will occur under the direct supervision of staff; Smoking assessments will be completed on admission, quarterly, and as needed only on residents who use tobacco products. 1. Review of Resident #16's medical record, showed:-re-admitted : 11/1/25;-Diagnoses included lung disease, disorientation, altered mental status, altered mental status, schizophrenia (a brain disorder that impairs the ability to think rationally, causing hallucinations, delusions and disorganized thinking), diabetes, depression, anxiety, fall history and asthma. Review of the resident's quarterly Minimum Data Set (MDS) a federally required assessment instrument completed by facility staff, dated (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	3/22/26, showed:-Severe cognitive impairment;-Used a wheelchair for mobility;-Dependent on staff for toileting and bathing;-Assist of one staff needed for dressing, bed mobility, and transfers;-No therapies received. Review of the resident's care plan, revised on 4/9/26, showed:-Focus: the resident has a self-care deficit due to disease process;-Goal: maintain current level of function in transfers, bed mobility, dressing and personal hygiene;-Interventions: transfer: the resident requires one staff participation with transfers. Review of the resident's electronic physician order sheet (ePOS), showed no transfer orders. Review of the resident's progress notes, showed:-On 6/10/26 at 11:10 P.M., a general progress note: the resident noted with deformed left leg and laceration to the right elbow. Notified by the certified nurse aide (CNA). The resident was sent to emergency room (ER) for evaluation and assessment;-On 6/11/26 at 1:55 A.M., diagnosis is a left femur fracture per hospital staff. Review of the resident's hospital history and physical, dated 6/11/26 at 5:11 A.M., showed:-Complaint: left leg problem;-History of present illness: the patient presents to the hospital with a left leg problem. Per emergency medical services (EMS), patient is alert and oriented x one (self) at baseline. Per previous notes, the aide at the care facility transferred the patient from the wheelchair to the bed. The patient's leg was stuck in the wheelchair and the left femur snapped. Per EMS, witness denies the patient fell. At the time of the interview, the patient said he/she fell, and his/her leg hurt. Per review of the notes, the orthopedic department pinned the bone in the ED, the head laceration also repaired;-Unable to review symptoms due to dementia;-Physical exam:--Appearance: ill appearing;--Head, ears, nose and throat (HENT): abrasion present;--Musculoskeletal:---Right lower leg: no edema (swelling);---Left lower leg: tenderness and bony tenderness present, no edema;---Skin: abrasion and signs of injury present;---Cognition: cognition is impaired;-Assessment and plan:--Fall: initial encounter, present on admission, not yet determined;--Closed fracture of left femur fracture: present on admission;-Computed tomography (CT, imagining used to create detailed imaging) lower left extremity, showed an acute displaced fracture of the femoral (long thigh bone) shaft. Osteopenia. Acute mildly displaced fracture of the femoral shaft with at least 12 centimeters overriding (a severe, high-energy injury characterized by massive muscle contracture and extreme leg-length discrepancy. Requiring immediate emergency stabilization with surgery). Post surgical changes of internal fixation are seen within the proximal femur;-Plan: orthopedics aware and planned surgery;-discharge: approximately 6/14/26 to a different facility with a wound vac in place, physical and occupational therapy orders. During an interview on 6/11/26 at 8:12 A.M., registered nurse (RN) R said he/she was the charge nurse on the evening of 6/10/26 and last saw the resident at approximately 8:50 P.M. and administered ordered medications. The resident was lying in his/her bed at that time. At approximately 11:05 P.M., to 11:10 P.M., the aide notified him/her the resident's leg was messed up. RN R said upon assessment the resident was in bed, his/her head faced the window. The resident's left leg was obviously deformed. RN R said he/she knew the resident's leg was broken by just looking at it. The resident experienced pain when he/she attempted to move the leg. The resident also had a fresh laceration above the right eyebrow. The certified nurse aide (CNA) B, who put the resident in bed, reported to RN R that when he/she transferred the resident into bed, the resident's left foot became entangled in the front wheelchair wheel, and the CNA completed the resident's transfer into bed. CNA B also told RN R he/she turned the resident in bed to provide care, and during the turning in bed, the resident struck his/her head on the wheelchair next to the bed. RN R said he/she immediately called emergency services for the resident to obtain treatment. During an interview on 6/11/26 at 10:30 A.M., CNA B said he/she had worked at the facility for five years and worked the evening shift on 6/10/26. He/She was scheduled to leave at 11:00 P.M. that evening and he/she had to ensure Resident #16 to bed before he/she left the shift. At approximately 10:55 P.M., CNA B entered the resident's room on 6/10/26 to put the resident to bed. The resident sat in his/her wheelchair. CNA B positioned the resident's wheelchair next to the bed. He/She applied the gait belt around the resident's waist and secured the gait belt. As he/she lifted the resident, and pivoted to the bed, the resident's foot got entangled in the front wheel (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	of the wheelchair. He/She and the resident fell sideways into the bed and the resident yelled out and then quieted. CNA B said he/she did not want the resident to slide off the bed and he/she straightened the resident in bed onto his/her back. CNA B unfasted the resident's brief, turned the resident on his/her side and provided care. As he/she turned the resident onto his/her back, the resident yelled out. As the resident lay on his/her back, CNA B said, it looked like the leg was out of socket. CNA B left the room and got RN R, told the nurse the resident's leg did not look right. CNA B said he/she needed to get the resident to bed before the end of his/her shift. He/She could not recall how the resident received a cut above the eye and said the resident could have hit his/her head on the wheelchair. He/She wrote a statement before he/she left the shift. He/She had been suspended, so the facility could investigate. During an interview on 6/12/25 at 2:05 P.M., the Administrator and Director of Nursing (DON), said Resident #16 was a gait belt pivot transfer. The resident resisted care at times. The facility has begun in servicing regarding transfers and reporting. Staff should have stopped the transfer any time the resident expressed discomfort. 2. Review of Resident #69's medical record, showed:-re-admitted : 2/14/26;-Diagnoses included seizures, stroke, sepsis (blood infection), muscle weakness, right knee contracture, difficulty swallowing, and right sided paralysis. Review of the resident's quarterly MDS, dated [DATE], showed:-Severe cognitive impairment;-Functional impairment upper and lower extremity to one side;-Used a wheelchair for locomotion;-Dependent on staff for transfers, mobility, hygiene and toileting;-Used a mechanical lift for transfers. Review of the resident's care plan, in use during the survey, showed:-Focus: The resident has decreased mobility and need of two staff assistance and a Hoyer lift (a mechanical list used to transfer non weight bearing patients) for safe transfers;-Goal: Safety measures will be taken when transferring the resident;-Interventions: Ensure two staff members are present when using Hoyer lift for safety measures. Observation and interview on 6/8/26 at 6:10 A.M., showed Certified Nurse Aide (CNA) B entered the resident's room with the Hoyer lift. Licensed Practical Nurse (LPN) S entered the room. Both staff applied the Hoyer sling under the resident and applied the sling to the lift arms. CNA B used the remote and lifted the resident off the bed and pulled the lift away from the bed. LPN S spun the resident in the lift to face CNA B. The resident swung freely over the floor as CNA B pushed the lift approximately four feet to the wheelchair. LPN S stood behind the wheelchair as CNA B pushed the resident over the wheelchair. LPN S pulled on the back of the sling, as CNA B lowered the resident into the wheelchair. CNA B said he/she should have asked LPN S to retain a hand on the resident during the positioning of the lift. The resident swung over the floor during the transfer. LPN S said he/she forgot to keep a hand on the resident during the transfer. Keeping hands on the resident ensured comfort and safety during the transfer. During an interview on 6/12/26 at 2:05 P.M., the DON said when staff used a mechanical lift, the staff who were not operating the lift should keep hands on the resident during the transfer. Residents should not freely swing over the floor while in the lift. 3. Review of the facility's smoking schedule, undated, showed smoking times:-7:30 A.M., 10:00 A.M., 1:30 P.M., 4:00 P.M., and 7:00 P.M. 4. Review of Resident #32's quarterly MDS, dated [DATE], showed;-Moderate cognitive impairment;-Diagnosis includes high blood pressure, kidney disease, stroke, and chronic (long term) lung disease. Review of the residents' care plan, in use at the time of survey, showed:-Focus: The resident smokes and has been advised of the facility smoking policy and requires supervision with smoking;-Interventions: Observe the resident during smoking for unsafe smoking (dropping cigarette, holding the cigarette close to the body) and report to nurse. Reassess resident smoking ability quarterly and after reports of unsafe practices. Remind resident and family member that the designated smoking areas are the only area to smoke. Remind the resident and family that all cigarettes, lighter, matchers and smoking paraphernalia must be kept at the nurses' station. Review of the resident's safe smoking evaluation dated, 4/24/26, showed:-Does the resident smoke?: Yes;-Does the resident know the location of the designated areas of smoking? No;-When observed, can the resident independent light smoking materials safely? No;-Can the resident extinguish smoking materials completely in an appropriate receptacle? No;-Can the resident dispose (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	of ashes or other tobacco-related residue appropriately? No;-If no to any of the above, explain: Blank;-The resident is safe to smoke with minimal supervision. Observation on 6/9/26 at approximately 6:30 A.M., showed the resident outside of the facility walking up and down the sidewalk in front of the facility smoking a cigarette. No staff member was present supervising the resident. During an interview on 6/12/26 at 1:11 P.M., the resident said he/she would let the staff know when he/she went out to smoke and they would let him/her out to smoke. That included smoking in the front of the facility on the sidewalk. 5. Review of Resident #66's quarterly MDS dated , 3/2/26, showed:-Cognitively intact;-Diagnoses included malnutrition (poor nutrition) and chronic lung disease. Review of the resident's care plan, in use at the time of survey, showed:-Focus: The resident smokes and has been advised of the facility smoking policy; The resident requires supervision with smoking;-Interventions: Observe the resident during smoking for unsafe smoking (dropping cigarette, holding cigarette close to body). Provide assistance as need to assist resident to and from smoking areas. Reassess the resident ?smoking ability quarterly and after reports of unsafe practices. Review of the resident safe smoking evaluation dated, 4/27/27, showed:-Does the resident smoke?: Yes;-Does the resident know the location of the designated areas of smoking? Yes;-When observed, can the resident independent light smoking materials safely? Yes;-Can the resident extinguish smoking materials completely in an appropriate receptacle? Yes;-Can the resident dispose of ashes or other tobacco-related residue appropriately? Yes;-The resident is safe to smoke with minimal supervision. Observation on 6/9/26 at 7:15 A.M., showed the resident propelled him/herself in the wheelchair out the designated smoking area on the first floor. The resident removed a pack of cigarettes and a lighter from the back pocket of his/her wheelchair. Ther resident lit and smoked his/her cigarette. When the resident was done smoking his/her cigarette, the resident placed his/her cigarettes and lighter back into the pocket on his/her wheelchair and propelled back into the facility. The Housekeeping Supervisor and CNA A were outside supervising the residents that were smoking. 6. Review of Resident #71's quarterly MDS, dated [DATE], showed:-Severe Cognitive Impairment;-Diagnoses included hypertension (high blood pressure), asthma (a chronic (long-lasting) inflammatory disease of the airways that causes the airways to spam and as well periodically so that the airways narrow), and stroke. Review of the resident's undated care plan, in use during the survey, showed:-Focus: The Resident is a smoker and has been advised of the facility smoking policy. The resident requires supervision with smoking. Resident offered Nicotine patch for smoking cessation due to inability to smoke at this time. Resident declined;-Goal: He/She will be compliant with facility smoking policy through review date;-Interventions: Observe Resident during smoking for unsafe smoking (dropping cigarette, hold to close to body etc.) and report to nurse. Offer and encourage use of Safety Devices (Smoking apron, holder) when smoking. Provide assistance as needed to assist resident to and from smoking area. Reassess resident smoking ability quarterly and after reports of unsafe practices. Remind family of need for Smoking apron for unsafe residents and that they must remain with the resident when smoking. Remind resident and family member that the designated smoking area is the only area to smoke in. Remind resident and family that all cigarettes, lighter, matches and smoking paraphernalia must be kept at nursing station. Review of the Resident's ePOS, showed no physician orders for smoking evaluations and/or assessments. Review of the Resident's medical showed:-On 4/9/26, a safe smoking evaluation completed:-Evaluation: Does the resident smoke: Yes marked;-Summary:--This resident is safe to smoke with minimum supervision: Not marked;--All smoking materials will be kept at the nurse's station: Not marked;--Additional information: No interventions needed at this time. Observations of the resident on 6/8/26, showed: `-At 6:06 A.M., he/she self-propelled him/herself down the hallway on the ground floor of the facility with a cigarette and a lighter in his/her hand. The Resident rolled past the conference room and went up the keypad located at the back exit door. He/She punched the code into the keypad and opened the door and exited out of the building. The resident positioned his/her wheelchair up against the building to the right side of the door and lit and then smoked his/her cigarette;-At approximately 6:20 A.M.; the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265672	A. Building B. Wing	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Wellness Center	3421 Gasconade Saint Louis, MO 63118

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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 - Actual harm Residents Affected - Few	Resident re-entered the building. He/she said he/she had no idea when the smoke times where. He/She smoked outside that exit door or on the first-floor patio. Staff took some of the residents out to smoke at that exit door sometimes. He/She smoked him/herself. He/She knew the code to the door and let him/herself out that door to smoke. He didn't remember how he/she had gotten the code, but just about everyone had the code to the door. 7. Observation on 6/10/26 at 4:52 P.M., showed multiple residents were observed punching in the code to the door alarm to go outside to the smoking area. Several staff members watched the residents exit onto the smoking patio. Observation on 6/12/26 at 9:45 A.M., showed a sign posted on the exit door to the smoking area showing smoking times: 7:00 A.M., 9:00 A.M., 11:00 A.M., 1:00P.M., 3:00 P.M., 5:00 P.M., 7:00 P.M., 9:00 P.M., 11:00 P.M. Four residents were observed in the outside smoking area with cigarettes and lighters. Residents were lighting each other's cigarettes. No staff were present supervision the residents smoking. During an interview on 6/12/26 at 9:00A.M., LPN C said residents were not to have cigarettes and lighters in their possession. The nurses or management were responsible for asking the resident to surrender the smoking items. A smoking assessment was completed quarterly. The residents had the code and let themselves out to the smoking area. Some of the residents signed out in the book and would go to the park or the front of the building and smoke. It was a work in progress, and the staff had been trying to enforce the smoking times, but it was hard when the residents had the code. During an interview on 6/12/26 at 9:20 A.M., CNA D said the residents had the code and let themselves out to the smoking area whenever they wanted. The residents had their own cigarettes and lighters. Management was aware residents knew the code and the residents had cigarettes and lighters, but they did not do anything about it. During an interview on 6/12/26 at 9:26 A.M., CNA E said the residents were not supposed to have cigarettes and lighters, but they had them anyway. CNA E said he/she notified management when the residents had smoking items in their possession. During an interview on 6/12/26 at 2:06 P.M., the Administrator and the DON said they would expect the smoking assessments to be completed quarterly. The residents were not allowed to have cigarettes or lighters in their possession. A meeting was held with the residents that smoked, and they were instructed not to use the door code. The residents were to follow the new smoking times that were recently put in place. Residents were expected to smoke in the designated smoking area and not in front of the building or in the park. All residents that smoke were supervised by staff at the designated smoking times. 3040593, 3040603, 3040173