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	08/30/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41061 Based on observation, interview and record review, the facility failed to treat each resident with respect and dignity when they failed to obtain proper Power of Attorney (POA, allows someone else to act on a resident's behalf) forms for two residents (Residents #2 and #1). The facility also failed to exercise patient rights of non-seclusion when they moved Resident #2 to a restricted environment without seeking alternative behavior interventions, assessments, or notifying a doctor. The sample size was three. The census was 77. Review of the facility's Resident Rights policy, revised [DATE], showed: -Policy: Employees shall treat all residents with kindness, respect and dignity; -Residents had a right to be free from corporal punishment or involuntary seclusion, and physical or chemical restraints not required to treat the resident's symptoms; -The unauthorized release, access or disclosure of resident information is prohibited. All release, access, or disclosure of resident information must be in accordance with current laws governing privacy of information issues. Review of the facility's Notification of Change policy, dated [DATE], showed: -Policy: The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification; -Circumstances requiring notification include: Significant change in the resident's physical, mental, or psychosocial condition such as deterioration in health, mental or psychosocial status; A change of room; A change in Resident's Rights; -Competent Individuals: The facility must still contact the resident's physician and notify resident's representative, if known; A family that wishes to be informed would designate a member to receive calls; When a resident is mentally competent, such a designated family member should be notified of significant changes in the resident's health status because the resident may not be able to notify them personally, especially in the case of sudden illness or accident; (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
	265736	A. Building B. Wing	08/30/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Residents incapable of making decisions: The representative would make any decisions that have to be made;The resident should still be told what is happening to him or her. 1. Review of Resident #2's POA forms, dated [DATE], showed: -The facility's former employee was named as the resident's durable power of attorney on [DATE]; -The POA form did not show the county, and was not signed or notarized by a Notary Public. Review of the resident's psychiatric progress note, dated [DATE], showed: -The resident was alert and oriented times ,d+[DATE] (person, place and time) with memory limited/poor immediate, recent past and remote memory; Attention and concentration were limited; Fund of general information was limited; Comprehension and understanding were limited; Judgment, insight and reliability appeared to be poor. Review of the resident's care plan, dated [DATE], showed: -Problem: Impaired cognitive function/dementia or impaired thought processes related to severe vascular dementia (problems with reasoning, planning, judgment, memory and other thought processes caused by brain damage) with behavioral disturbances. Interventions included: Communicate with resident/family/POA regarding any capabilities and needs; Cue, reorient and supervise as needed; Discuss concerns with confusion, disease process and nursing home placement with the resident /family/POA as needed; Keep the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated [DATE], showed: -admitted on [DATE]; -Moderate cognitive impairment -Impairment on both sides of lower body; -Independently used wheelchair for locomotion; -Diagnoses included anxiety, non-traumatic brain dysfunction, depression, dementia and bipolar disease (psychiatric illness characterized by both manic and depressive episodes, or manic ones only). Review of the resident's Provider Orders for Life-Sustaining Treatment (POLST) Model Form: A portable medical order, undated, showed: -Full Cardiopulmonary resuscitation (CPR): attempt resuscitation, including mechanical ventilation (insert a tube in the throat to aide in breathing), defibrillation (electrical shock to start heart or change heart rhythm) and cardioversion (electrical shock to attempt to change heart rhythm) was selected; (continued on next page)

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	08/30/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Full Treatment to attempt to sustain life by all medically effective means was selected; -The former Admissions employee signed the form, failing to write his/her authority to sign or date the signature; -On [DATE], the Primary Care Physician (PCP) signed the form to accept as an order. Review of the facility's incident and accident report, dated [DATE] through [DATE], showed no incident documented for the resident on [DATE]. Review of the resident's Medication Administration Record (MAR), dated [DATE] through [DATE], showed no aggressive/combative behavior documentation. Review of the resident's progress notes, showed: -On [DATE] at 8:05 P.M., the resident's family member was at the facility, upset that the resident was in the locked memory unit. The Assistant Director of Nursing (ADON) was notified and gave an order to transfer the resident back to his/her previous room; -There was no other documentation found showing why or when the resident was transferred to the locked memory unit, who made the decision, or any notification to the PCP, Psychiatrist or resident's family member. Observation on [DATE] at 8:22 A. M., showed the resident sat in a wheelchair in the dining room, alone at a table with a cup of juice and a cup of water. The resident drank all the water out of his/her cup, then would take a drink of the juice and spit it out into the empty water cup. The resident did this several times. During an interview on [DATE] at 8:25 A.M., the resident said: -He/She wanted to go home; -He/She could not answer any questions regarding a room change or how it made him/her feel; -He/She could not remember peeling wallpaper off the wall. During an interview on [DATE] at 2:40 P.M., Graduate Practical Nurse (GPN) E said; -Nurses were expected to document in a resident's electronic medical record (EMR) when a resident had a behavior that was out of the ordinary. They were expected to document what happened, who was involved, what staff did to stop the behavior, the assessment of the resident, and to call the PCP to get new orders, if applicable. They would also call the POA or emergency contact and inform their supervisors; -Nurses were expected to document when residents moved rooms, and contact the POA or resident's responsible party in the resident's EMR; -He/She was the nurse assigned to the resident's care on [DATE]; (continued on next page)

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	08/30/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She did not know what happened to cause the resident to get moved from his/her regular room to the locked memory unit; -He/She was told by the Social Services Designee (SSD) that he/she was moving the resident to the locked memory unit without any explanation; -He/She expected the SSD to document the details of what happened and why the resident was moved the locked memory unit and whom she notified on [DATE]; -He/She made the ADON aware the note was missing in the resident's EMR and the ADON said she would look into it; -The resident had a POA, who was a family member. During an interview on [DATE] at 3:28 P.M., Certified Nurse Assistant (CNA) B said: -On [DATE], he/she was assigned to care for the resident; -He/She was told to move the resident's belongings to a new room in the locked memory unit; -He/She could not remember who gave the direction, just that it was a manager; -He/She did not know why the resident was moved to the locked memory unit but heard it was because the resident was peeling wallpaper off the wall; -He/She expected the facility to notify the resident's family member of the room change, especially since the resident had a POA previously. During an interview on [DATE] at 3:49 A.M., the SSD said: -The resident had a facility employee listed as his/her POA for the last two years; -It was discovered a month or so ago the former facility employee did not have the appropriate POA forms filled out; -The facility acted as if the former employee was the resident's POA for almost two years with out appropriate documentation; -The resident's family member turned in POA forms approximately two weeks ago but they were not correct. The family member was informed and given the opportunity to come back in and fill out the correct form using the Nurse Practitioner as the notary. The family member never came back in to fill out the POA forms; -The resident was then responsible for self; -The resident was not always able to make safe decisions for him/herself or understand his/her medical condition due to his/her cognitive status and diagnosis of dementia; (continued on next page)

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	08/30/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On [DATE], she was in an office with the ADON, located in the front entry, when a staff member came and informed them the resident was in his/her wheelchair, peeling wallpaper off the wall in the entry way; -She could not recall who notified them the resident was peeling wallpaper off the wall; -Both she and the ADON went out to investigate and saw the resident was peeling wallpaper off the wall with about five or six strips peeled off; -SSD asked the resident why he/she was doing that and the resident responded to help the maintenance men because they were painting walls; -The resident stopped the behavior when the SSD asked. The resident was not upset or angry; -The ADON made the decision to move the resident to the facility's locked memory care unit, because the resident's act was a behavior; -The SSD defined a behavior as a resident acting out to hurt themselves or others, repeating the behavior and staff not able to redirect the resident; -The resident was redirectable and was not peeling the wallpaper off the wall in an angry or spiteful manner; -SSD removed the resident from the entryway, took him/her to the locked memory unit and informed both the nurse on duty in the locked memory unit and the nurse originally assigned to the resident, the resident was to move to a new room in the locked memory unit; -The resident was quiet, did not seem upset and did not ask any questions about what was happening; -The SSD did not inform the PCP or the resident's emergency contact. It was an error not to inform them and she was not sure why she didn't call them; -The SSD did not write a note in the resident's EMR detailing the event, what exactly happened, how the resident was easily redirected to stop peeling off the wallpaper, was educated why it was not okay to peel off the wallpaper, who made the decision to move the resident to the locked memory unit and why; -The resident's typical behavior was to propel him/herself in his/her wheelchair around the facility, visiting different rooms and interacting with staff and other residents; -The resident was not a threat to him/herself or others; -Placing the resident in the locked memory unit was a restriction on the resident's rights. During an interview on [DATE] at 4:28 P.M., the ADON said: (continued on next page)

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	08/30/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-When the resident was originally admitted to the facility, a former employee said the resident's family member asked him/her to be the resident's POA. The former employee filled out the POA forms, as he/she was working as Admissions at the time; -The facility acted in good faith that the former Admissions employee was the resident's POA for almost two years; -She was not sure when she found out the former employee did not have the appropriate POA forms filled out, it might have been a month or so ago; -The former employee was terminated on [DATE] for lack of job performance; -The resident was then made his/her own responsible party; -The resident's family member brought in POA paperwork approximately two weeks ago and submitted it to the ADON; -Upon review, the ADON found the POA forms were not filled out correctly and the resident's family member was informed they could not accept it until it was corrected; -The resident was made his/her own responsible party; -An incident or accident was an occurrence of some sort like a resident to resident altercation, a fall, an injury of unknown origin or a behavior by a resident if it was causing an uproar of the environment; -She expected staff to notify the PCP of any new behaviors for new orders. She also expected staff to notify the resident's Psychiatrist if a resident was exhibiting any new behaviors; -She expected staff to document the details of the incident in residents' EMR, including the nature of the behavior, how they tried to redirect the resident, what interventions were tried and what were the results. She also expected staff to notify management, the PCP and the resident's POA or family member; -She expected staff to notify the POA of any change of condition, change of medication, any falls, behaviors, or room changes and to document when they notified the POA, what was said and the results of the conversation; -Residents were moved to the locked memory unit when they were not able to make safe decisions for themselves, were in danger of hurting themselves or others, were exit seeking, an elopement risk or at risk for wandering. The locked memory care unit was not there to use to deter residents from behaviors that did not harm themselves or others; -On [DATE], the SSD came and told her the resident was peeling wallpaper off the wall and decided to move the resident to the locked memory care unit; -The resident was destructive to property because he/she tore wallpaper off the wall when staff was not present; (continued on next page)

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	08/30/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-She did not question why the SSD made that decision and she did not ask; -She was not aware the resident was easily re-directed and the resident thought he/she was helping the maintenance staff by pulling the off the wallpaper so they could paint; -The resident was safe with others, would sometimes create disturbances by yelling for things, like he/she needed a band aid; -She expected the SSD to report what happened to the nurse so the nurse could notify the PCP and Psychiatrist for new orders before moving the resident to a restricted environment; -The resident was considered his/her own responsible party so there was no need to notify the family of a room change; -She could not answer why the resident was put in the locked memory unity when he/she could not make safe decisions for self due to peeling wallpaper off wall but still was considered her own responsible party with a Brief Interview of Mental Status (BIMS, a brief screener of cognition) of 8 out of 15 and a diagnosis of dementia; -She expected both the SSD and the nurse to document all details of the incident and the resulting room change in the resident's EMR, so the management team could follow up on the event to make sure all parts of the incident report were completed and the care plan updated; -She was not sure why the incident was not included in the facility incident/accident report; -She was responsible to make sure the facility incident/accident report was updated and proper documentation was included in the resident's EMR; -She had not checked documentation on the event since it occurred; -She was responsible to check nursing documentation daily; -The entire procedure was not done correctly; -Residents had a right to be in the least restrictive environment; -Before moving to the locked memory unit, the PCP and Psychiatrist were notified to see if there are any new orders, such as a pharmacy review, labs or counseling were necessary and the Interdisciplinary Team (IDT) would meet to see if all appropriate interventions were tried, if new interventions were necessary and then a meeting between the family and the resident would place to involve them of the decision; -The resident's family member was very upset the resident was moved to the locked memory unit without notification to him/her and had made a report to the police; -The ADON told the family member the facility did not have to notify him/her of the resident's room change because the family member had not filled out the POA forms correctly and therefore the resident was responsible for self. (continued on next page)

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	08/30/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 12:21 P.M., the Assistant Administrator said: -She was not sure why the resident was moved from his/her regular room back to the locked memory unit. She heard in the morning meeting the next day it was because the resident was pulling wallpaper off of the wall in the entryway of the building; -She did not know what interventions the staff tried before making the decision to move the resident to the locked memory unit; -She expected the SSD to talk to the nurse, explain what she saw the resident doing in terms of tearing wallpaper off the wall, the nurse to assess the resident and to call the PCP to get an order for the resident to get moved to the locked memory unit as it was a more restrictive environment. Failure to do so was against Resident Rights; -She expected the SSD to document in the resident's EMR the description of the behavior, what interventions she tried, whom she told and the conclusion of the event; -She expected the nurse to document in the resident's EMR the description of the behavior, the assessment of the resident, notification to the PCP and what the PCP said or any new orders; -She expected staff to document when the resident was moved from his/her regular room to the locked memory unit and when he/she was moved back into his/her regular room; -She expected the staff to follow the change of condition policy as the behavior was outside of the resident's normal baseline behaviors; -She did not expect staff to contact the resident's family member because the resident was responsible for self, even though the resident had a BIMS of 8 and the family member was seeking to complete POA forms prior to the event. 2. Review of Resident #1's care plan, dated [DATE], showed: -Problem: Impaired cognitive function/dementia or impaired thought processes related to moderate dementia. Interventions included communicate with resident/family/POA regarding capabilities and needs; Discuss concerns with confusion, disease process and nursing home placement with the resident/family/POA as needed. Review of the resident's annual MDS, dated [DATE], showed: -admitted on [DATE]; -Severe cognitive impairment; -Diagnoses included non-traumatic brain dysfunction, stroke and dementia. Observation on [DATE] at 9:18 A.M., showed the resident lying in his/her bed covered with a sheet and blanket. (continued on next page)

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	08/30/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's face sheet (a document that gives resident's information at a quick glance), dated [DATE], showed the resident's family member was the resident's Financial and Health Care POA. During an interview on [DATE] at 5:06 P.M., the ADON said the resident's family member was his/her POA. Review of a faxed document received on [DATE], showed the ADON documented the resident did not have a POA according to the resident's master in the house file. 3. During an interview on [DATE] at 3:49 A.M., the SSD said: -She was responsible for reviewing the POA forms for completeness and to upload them into resident's EMR; -When a resident had a POA, it was the facility's procedure to notify the POA of any change of condition, medication change, incidents and accidents, and/or room changes and to document in resident's EMR when they were notified and what was said. During an interview on [DATE] at 4:28 P.M., the ADON said the Admissions employee was responsible for ensuring POA forms were filled out correctly, uploaded into the residents' EMR and documented on the residents' face sheet. During an interview on [DATE] at 12:21 P.M., the Assistant Administrator said: -She expected the facility to have the correct POA forms uploaded in resident's EMR; -She expected staff to know when a resident had a POA or was responsible for self. MO00240191

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	08/30/2024

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 41061 Based on observation, interview and record review, the facility failed to ensure activities of daily living (ADL) care needs were met for dependent residents. The facility failed to provide perineal care (peri-care, washing the front and back of the hips, genitals, anal area and buttocks) timely and appropriately after an incontinence episode for one resident (Resident #1) out of three sampled residents. The census was 77. Review of the facility Activities of Daily Living (ADL), Supporting policy, revised March 2018, showed: -Policy statement: Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene; -Residents will be provided with care, treatment and services to ensure that their activities of daily living (ADLs) do not diminish unless the circumstances of their clinical condition(s) demonstrate that diminishing ADLs are unavoidable; -Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene and elimination. Review of Resident #1's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 5/29/24, showed: -Cognitively impaired; -Impairment on both sides of lower body; -Dependent for toileting and transfers; -At risk for pressure ulcers; -Always incontinent of bladder and bowel; -Diagnoses included diabetes mellitus, stroke and dementia. Review of the resident's care plan, dated 6/3/24, showed: -Problem: Risk of skin breakdown related to total incontinence of bowel and bladder; -Interventions included: Requires total assist of one staff for toileting hygiene; Provide incontinence care and barrier cream after each incontinent episode and as needed. (continued on next page)

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	08/30/2024

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 8/21/24 at 9:18 A.M., showed the resident lay in his/her bed, with the head of the bed raised slightly, and covered with a blanket. During an interview on 8/21/24 at 9:25 A.M., the resident said: -The last time staff had cleaned him/her up after an incontinence issue was sometime last night; -Staff had not attended to his/her incontinence needs that morning. During an interview on 8/21/24 at 9:50 A.M., Certified Nursing Assistant (CNA) A said: -CNAs were expected to make rounds every two hours for ADL dependent residents, checking them for incontinence needs, repositioning to prevent skin breakdown, ensuring residents had fresh water and asking them if all their needs were met; -CNAs were informed of residents who were ADL dependent from other CNAs during shift change report or by the residents' chart. Observation on 8/21/24 at 10:01 A.M., showed: -CNA B and CNA C in the resident's room, both wearing gloves and standing near a sink of running water with a bath towel half submerged in the water; -The resident lay flat in his/her bed, covered with a sheet; -CNA B removed the sheet from the resident, exposing the resident's bare legs and brief; -The brief was soaked with urine; -CNA B and CNA C worked together to roll the resident back and forth in order to remove the urine soaked brief from the resident's person; -The resident's perineal area was visibly wet from the urine soaked brief; -CNA B threw the urine soaked brief in the trash; -CNA B and CNA C removed their gloves and discarded them in the trash; -CNA C covered the resident with a blanket, raised the head of the bed to a 90 degree angle and clipped the resident's call light on his/her blanket, within reach; -CNA B and CNA C stood in the room, chatting about how warm the room was before exiting room at 10:17 A.M.; -CNA B and CNA C failed to perform perineal care after the resident was incontinent of bladder and failed to put a clean brief on the resident. Observation on 8/21/24 at 10:26 A.M., showed: (continued on next page)

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	08/30/2024

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-CNA A and CNA D entered the resident's room, sanitized their hands and donned gloves; -The resident lay in his/her bed, covered with a blanket; -CNA D removed the blanket from on top of the resident, exposing the resident's bare perineal area and bare legs; -CNA A retrieved a clean brief and put it on the resident's bed; -CNA A and CNA D worked together to roll the resident back and forth in order to place the clean brief on the resident; -CNA A and CNA D dressed the resident and, using a mechanical lift, transferred the resident to his/her wheelchair; -CNA A removed the dirty linen and trash, and left the room; -CNA A and CNA D failed to perform perineal care before putting a new, clean brief on the resident. During an interview on 8/21/24 at 11:03 A.M., CNA A said: -He/She did not perform perineal care on the resident before putting a new clean brief on him/her because CNA B and CNA C told him/her they had already cleaned up the resident; -Cleaned up the resident meant they had performed perineal care; -He/She expected staff to perform perineal care on residents after an incontinence episode to prevent skin breakdown, infection, and to respect the residents' dignity. During an interview on 8/21/24 at 1:24 P.M., the resident said: -He/She did not feel clean when the CNAs did not wash him/her after he/she was incontinent of his/her bladder; -He/she felt uncared for and treated like trash by the CNAs; -He/She often was left wet and unwashed after incontinence episodes. During an interview on 8/21/24 at 2:40 P.M., Graduate Practical Nurse (GPN) E said: -He/She expected CNAs to perform perineal care on residents after an incontinence episode, washing every area that came in contact with urine and/or bowel movement; -The residents were at higher risk of skin breakdown if they were not cleaned appropriately after incontinence; -Failure to give residents basic care was a form of neglect. (continued on next page)

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	08/30/2024

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/21/24 at 3:01 P.M., CNA C said: -He/She would perform perineal care after a resident was incontinent, before putting on a clean brief, to prevent skin breakdown; -He/She did not know why he/she did not perform perineal care on the resident, washing away any urine on the resident's skin after he/she removed the urine soaked brief from the resident; -He/She should have cleaned up the resident after he/she was found with a urine soaked brief to prevent skin breakdown. During an interview on 8/21/24 at 3:17 P.M., CNA B said: -He/She would wash up a resident after they were incontinent of bladder or bowel by using a no rinse soap, drying the resident, applying any barrier creams to protect residents' skin before putting a clean brief on the resident; -Failure to perform perineal care after incontinent episodes put the residents at a higher risk of skin break down, burning of the skin and development of open sores; -He/She did not know why he/she did not perform perineal care on the resident after removing the urine soaked brief; -He/She put the resident at risk of skin breakdown and probably made him/her feel pretty bad when perineal care was not performed. During an interview on 8/26/24 at 12:21 P.M., the Assistant Administrator said: -She expected staff to care for residents who were dependent for ADLs by rounding on them every two hours, checking on incontinence and providing care as needed; -She expected staff to perform perineal care after a resident was incontinent of bladder or bowel, to change the brief, change sheets if needed, and replace the resident's call light in reach before leaving the room; -Failure to perform perineal care after incontinence increased the resident's risk of skin breakdown, infection and also did not respect a resident's right to dignity. MO00239876

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	08/30/2024

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 49992 Based on interview and record review, the facility failed to provide a Registered Nurse (RN) for eight consecutive hours per day, seven days a week. This deficiency had the potential to affect all residents. The census was 75. Review of the facility's daily assignment sheets, showed there was no RN in the facility on 8/16, 8/17, 8/18, 8/20, 8/23, 8/27, 8/28 and 8/30/24, for a total of 8 out of 15 days. During an interview on 8/30/24 at 12:46 P.M., the Assistant Director of Nursing (ADON) said the facility only had one RN on staff who worked full time. The ADON is aware the facility is required to have an RN in the facility for eight consecutive hours per day, seven days a week. During an interview on 8/30/24 at 12:46 P.M., the Assistant Administrator (AA) was aware the facility has not had continuous RN coverage. He/She said they have been actively recruiting, offering a $5000.00 sign on bonus but have been unsuccessful. The AA said the facility had to have RN coverage eight hours a day, seven days a week.

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	08/30/2024

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 41061 Based on observation, interview and record review, the facility failed to maintain an effective pest control program to control the presence of cockroaches in the facility when a cockroach was crawling on a resident's blanket while the resident was lying in his/her bed (Resident #1). This had the potential to affect all residents. The census was 77. Review of pest control company service report, dated 8/19/24, showed: -Service provided: Roach clean out in the kitchen and in the rooms for roaches. This service will continue to reduce and eliminate German roaches (a small, tan to black cockroach commonly found indoors) throughout the area, kitchen, therapy room and the room; -Treated with an ultra-low volume sprayer to knock down German Roach infestation. Review of Resident #1's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 5/29/24, showed: -Cognitively impaired; -Impairment on both sides of lower body; -Dependent for toileting and transfers; -Always incontinent of bladder and bowel; -Diagnoses included diabetes mellitus, stroke and dementia. Observation on 8/21/24 at 9:18 A.M., showed: -The resident lay in his/her bed covered with a sheet and blanket; -A small, tan cockroach crawled on top of the resident's blanket, scuttling across the blanket from the resident's waist towards the resident's feet. Observation on 8/21/24 at 9:21 A.M., showed the Housekeeping Supervisor (HKS) entered the resident's room, saw the cockroach running across the resident's blanket towards the foot board of his/her bed. The HKS flicked the cockroach off of the resident's blanket on to the floor with his/her fingers. The HKS then stomped on the cockroach, killing it. She then wiped up the smashed cockroach off of the floor with a paper towel. During an interview on 8/21/24 at 9:25 A.M., the resident said: -He/She was in a different room a few weeks ago that was infested with cockroaches, so the facility moved him/her to his/her present room; (continued on next page)

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	08/30/2024

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She had not seen cockroaches in his/her present room. During an interview on 8/21/24 at 9:50 A.M., Certified Nurse Assistant (CNA) A said: -He/She started working at the facility three years ago; -The facility had cockroaches in the building since he/she first started working; -The facility had a pest control company come in once a month to spray for cockroaches but there were still cockroaches in the building. During an interview on 8/21/24 at 10:57 A.M., the HKS said: -She confirmed there was a cockroach crawling on the resident's blanket earlier that morning, which she flicked off the bed and smashed it on the ground; -There was an on-going problem with cockroaches in the facility; -The facility was sprayed for cockroaches on the other hall recently and she wondered if the cockroaches just traveled to a new area of the facility. During an interview on 8/26/24 at 12:21 P.M., the Assistant Administrator said: -She expected staff and/or residents to report any cockroaches in the building; -She had not had any complaints of cockroaches since 8/1/24; -A pest control company came in at least once a month to treat; -She expected the residents' beds and rooms to be free of cockroaches. MO00239876