STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265736	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide reasonable accommodation of individual needs and preferences by failing to ensure call lights were in reach for two residents (Resident #26 and Resident #5). The sample size was 20. The census was 81. Review of the facility's Answering the Call Light policy, last revised, July 2014, showed:-Purpose: The purpose of this procedure is to respond to the resident's requests and needs;-General guidelines: When the resident is in bed or confined to a chair, be sure the call light is within easy reach of the resident. Some residents may not be able to use their call light. Be sure these residents are checked on frequently. 1. Review of Resident #26's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/23/25, showed:-Diagnoses included type two diabetes, acute kidney failure, and acquired absence of right leg above the knee;-Cognitively intact. Review of the resident's 5-day MDS, dated [DATE], showed:-Moderately impaired cognition. Review of the resident's care plan, in use at the time of the survey, showed:-Focus: Resident admitted to the facility for long term care. Resident requires a baseline care plan identifying care needs, risks, strengths and goals within the first 48 hours;-Goal: Resident will have access to necessary services to promote adjustment to new living environment in the facility;-Approach: Safety: Resident will need to be monitored to prevent falling in new environment. Resident will need assistance with bed/chair mobility, assistance with transfers, assistance with locomotion to prevent falling or injury. Resident uses a wheelchair and needs safety reminders to use durable medical equipment safely;-The care plan did not address the resident's falls or any fall interventions put in place. Review of the facility's facility event summary report, dated 12/23/25 through 3/23/26, reviewed on 3/23/26, showed:-On 12/24/25 at 6:42 P.M, the resident had an unwitnessed fall;-On 1/6/26 at 7:25 A.M., the resident had an unwitnessed fall;-On 1/11/26 at 4:00 A.M., the resident had an unwitnessed fall;-On 1/29/26 at 11:11 A.M., the resident had a witnessed fall;-On 1/29/26 at 12:32 P.M., the resident had a witnessed fall;-On 2/17/26 at 11:40 A.M., the resident had an unwitnessed fall;-On 2/28/26 at 5:46 P.M., the resident had a fall;-On 3/14/26 at 12:45 P.M., the resident had a fall;-On 3/19/26 at 4:40 P.M., the resident had an unwitnessed fall. Observation on 3/25/26 at 6:47 A.M., showed the resident sat in his/her wheelchair by the door on the left side of his/her bed. The resident was asleep. The call light was out of reach. Observations on 3/26/26 at 6:51 A.M., 7:46 A.M., 9:36 A.M., 9:54 A.M., and 11:08 A.M., showed the resident in his/her room. He/She sat in his/her wheelchair next to the left side of the bed, by the door. The resident was asleep. The resident's call light was out of reach, on the ground on the right side of the resident's bed. Observation on 3/27/26 at 10:00 A.M., showed the resident in his/her room. He/She sat in his/her wheelchair by the door on the left side of the bed. The resident was asleep. The call light was out of reach, on the ground under the resident's bed. During an interview on 3/27/26 at 6:29 A.M., Licensed Practical Nurse (LPN) A said he/she would have expected the call light to always be within reach of the resident. He/She said the resident fell frequently and liked to sleep in his/her wheelchair. During an interview on 3/26/26 at 10:52 A.M., the Director of Therapy said the resident was receiving physical therapy, occupational therapy, and speech therapy. Her recommendation for the resident was he/she should have been in a wedge (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: 265736	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2026

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wheelchair (tilted wheelchair) with foot pedals to prevent further falls. She expected the resident's call light to be in reach at all times. She also expected nursing staff to conduct more frequent rounding on the resident. 2. Review of the Resident #5's care plan, in use at the time of survey, showed: -Focus: The resident is at risk for dehydration:-Intervention: Keep call light within reach while the resident is in their room and remind the resident to call for assistance when needed;-Focus: The resident is at risk for increased complaints of pain due to contractures, skin integrity issues and hospice care;-Intervention: Have call light within reach while the resident is in their room. Review of the resident's medical record, showed diagnoses included Alzheimer's disease and dementia. Observation on 3/25/26 at 8:53 A.M. and 10:07 A.M., showed the resident lay in bed. The resident was unable to communicate, and all four extremities were contracted. The resident's call light was positioned at the foot of the resident's bed, out of the resident's reach. Observation on 3/26/26 at 6:30 A.M., 8:55 A.M. and 10:58 A.M., showed the resident lay in bed. The resident was unable to communicate, and all four extremities were contracted. The resident's call light was on the floor under the resident's bed, out of the resident's reach. During an interview on 3/27/26 at 10:28 A.M., LPN C said the resident's call light should be positioned within the resident's reach even though he/she could not use the call light. During an interview on 3/27/26 at 8:39 A.M., Certified Nursing Assistant (CNA) B said the call light should be within the resident reach no matter what the residents cognition status was. If the resident could not use the light, then frequent rounding was to be completed. 3. During an interview on 3/27/26 at 12:46 P.M., the Administrator and Director of Nursing (DON) said they would have expected call lights to be in reach of all residents at all times while they were in their rooms no matter what their cognition status was. After providing care, staff should ensure residents had their call light before exiting the room. They would have expected a resident who had frequent falls to have their call light within reach.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, interview and record review, the facility failed to ensure one resident's right to be free from physical abuse when Restorative Aide/Certified Nursing Assistant (CNA) E grabbed the resident's right arm from behind him/her to put the arm on his/her lap. The resident was non-verbal and provided several non-verbal actions of refusal when Restorative Aide/CNA E pried the resident's fingers off the wheelchair (WC) wheel and pulled the arm forward so forcefully that it nearly caused the resident to fall forward out of the chair (Resident #34). The sample size was 20. The census was 81. Review of the facility's Abuse policy, dated September 2022, showed: Definitions:-Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with the resulting physical harm, pain, or mental anguish. Abuse also included the deprivation by an individual, including a caretaker, of goods or service that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instance of abuse of all residents, irrespective of any mental anguish. It included verbal abuse, sexual abuse, physical abuse, and mental abuse including facilitated or enabled using technology. Nursing home staff are prohibited from taking or using photographs or recording in any manner that would demean or humiliate a resident. This would include using any type of equipment (cameras, smart phones, and other electronic devices to take, keep or distribute photographs and recordings on social media). Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflect injury or harm.-Procedures for Prevention:--Orientation and Training of Employees: During the orientation of new employees, the facility will cover at least the following topics;--A. Sensitivity to resident's rights and resident needs;--H. Nurses aides must have received initial and annual abuse prevention training;-Internal Reporting Requirement and Identifications of Allegations:--Employees are required to report any incident, allegation, or suspicion of potential abuse, neglect, or misappropriation of property they observe, hear about, or suspect immediately to the administrator. All resident, visitors, volunteer, family members or other are encouraged to report their concerns, suspected may be made without fear of retaliation. The administrator has a responsibility to ensure that retaliation is prevented and prohibited. Notice of employee rights regarding non-retaliation for reporting the suspicion of a crime are posted in areas of the facility conspicuous to staff. Anonymous report will also be thoroughly investigated;--Internal investigation of abuse, neglect or misappropriation allegations and response;---All incidents will be documented, whether abuse occurred, was alleged or suspected;---Any incident or allegation involving abuse, neglect, or misappropriation will result in an abuse investigation. Review of Resident #34's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 06/24/25, showed:-Severely impaired cognition;-Mood: Resident rarely feels isolated, and no behaviors marked;-Resident is fully dependent on assistance from staff for all activities of daily living (ADLs);-Weight 213 pounds (lbs.). Review of the resident's care plan, in use at the time of survey, showed:-Problem: Communication, the resident has impaired cognitive function/decision making skills related to unspecified intellectual disability with unclear speech. Often repeats words or phrases heard by others.-Goal: Will remain safe, and needs to be anticipated and met through next review date;-Approach: Explain any procedure being done prior to carrying out task, provide ques and reorientation as needed, provide simple choices, use alternative forms of communication (pictures, communications board, etc.) as needed. Observation on 03/24/26 at 12:47 P.M., showed the resident was positioned at the nurse's desk. The resident had his/her arm positioned on the back of the wheelchair and the lower part of his/her arm looped around the handlebar of the WC. Restorative Aide/CNA E stood to the right of the resident and kept grabbing at the resident's right arm to move it forward. The resident made non-verbal actions towards the staff by moving his/her arm away from Restorative aide/CNA E. The resident propelled him/herself forward a little bit and grabbed onto the WC wheel. Restorative Aide/CNA E pried the resident's (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	fingers off the wheel of the chair. Restorative Aide/CNA E grabbed the resident's arm. Restorative Aide/CNA E held the resident's right arm in his/her right hand. Restorative Aide/CNA E's left hand was placed behind the resident's right arm triceps (above the elbow) area. Restorative Aide/CNA E forcefully jerked the resident's right arm forward, to the point the resident lost balance in a seated position and nearly fell forward onto the tile. Observation on 03/24/26 at 12:49 P.M., showed Restorative Aide/CNA E wiped the resident's hands off and a red substance was on the washcloth. The resident sat in the wheelchair by the wall around the corner from the dining room entrance. During an interview on 03/24/26 at 12:50 P.M., the resident said staff were rough, and he/she was afraid. Review of the facility's security camera system on 03/24/26 at approximately 1:00 P.M., with the Administrator, Assistant Administrator, Director of Nursing (DON), and Assistant Director of Nursing (ADON) present, showed: The resident was in his/her WC at the nurse's desk. Restorative Aide/CNA E stood parallel to the resident. Restorative Aide/CNA E attempted to reposition the resident's arm. The video showed Restorative Aide/ CNA E tugging and pulling on the resident's arm in a forward motion, so much that the seated resident's entire body went forward, nearly causing the resident to fall out of his/her WC. During an interview on 03/24/26 at 1:06 P.M., after watching the video footage of the incident, the DON said because the resident was propelling forward and then the resident's arm flared outward, Restorative Aide/CNA E should have stopped. The DON said excess force should not occur, and the employee should have reapproached the resident at a later time. During an interview on 03/24/26 at 1:06 P.M., after watching the video footage of the incident, the ADON said the resident was known for resting his/her arm behind the chair. The ADON said she saw the staff member put the resident's arm to the front, and staff placed the resident's arm again to the front because the resident was resisting to put his/her arm where the staff member wanted it. During an interview on 03/24/26 at 1:06 P.M., after watching the video footage of the incident, the Administrator said this resident needs several ques. During an interview on 03/24/26 at 1:06 P.M., after watching the video footage of the incident, the Administrator, DON and ADON said the staff member used excessive force with the resident. Review of the facility's investigation report dated 03/24/26, showed review of the camera footage found the employee was aggressively repositioning the resident multiple times. The resident can be seen refusing any further assistance and the employee became more aggressive. During an interview on 03/24/26 at 1:12 P.M., Restorative Aide/CNA E said the resident does like to sit with his/her arm behind the chair. Restorative Aide/CNA E tried to reposition the resident's arm at the resident's request. Restorative Aide/CNA E said You saw me reposition his/her arm and that's when he/she fell, and I caught the resident. The resident had his/her hand locked on the WC wheel and that's when Restorative Aide/CAN E moved the resident's hand off the wheel. The resident complained his/her arm hurt. Restorative Aide/CNA E saw a red substance on the resident's arm, but it was ketchup from lunch. Restorative Aide/CNA E did not believe he/she was being rough with the positioning of the resident's arm. Earlier in the day, the resident was not himself/herself. The resident had jerky movements, and Restorative Aide/CNA E informed the nurse on shift. During an interview on 03/24/26 at 1:30 P.M., Licensed Practical Nurse (LPN) C said he/she did not recall any abnormal behaviors or unusual body movements when he/she assessed the resident earlier. The resident will comply with directions, but it depends on the resident's mood. The resident always had his/her arm resting behind the WC. LPN C has cared for the resident for three months and never had to reposition his/her arm or heard the resident complain the arm hurt when seated in this position. Restorative Aide/CNA E said the resident almost fell this morning. Restorative Aide/CNA E said the resident would not sit up and looked like he/she could fall out of the WC. When LPN C saw the resident, he/she was without distress in the kitchen. During an interview on 03/26/26 at 8:03 A.M., Laundry Assistant S said he/she passed by and saw Restorative Aide/CNA E yelling and grabbing at the resident. By that time, the resident was resistant and fought to get Restorative Aide/CNA E off him/her. Restorative Aide/CNA E pulled and tugged on the resident, so much that Laundry Assistant S thought the resident must have bruises or some kind of injury. After the incident, Laundry Assistant (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	S tried to speak with the resident, who became withdrawn and sat in a corner. Laundry Assistant S believed the incident affected the resident. Laundry Assistant S never saw Restorative Aide/CNA E behave in this manner previously. Laundry Assistant S could not intervene safely, due to Restorative Aide/CNA E being right up on the resident. During an interview on 03/24/26 at 1:41 P.M., the Administrator said the facility concluded their investigation, and the decision was to terminate Restorative Aide/CNA E for abuse. 2963114

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F 0686 Level of Harm - Minimal harm or potential for 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 appropriate treatments and assessments for two of two residents sampled for wounds (Residents #88 and #77). The facility failed to administer treatments on a consistent basis and failed to enter an order in the electronic medical record (EMR) for a newly identified wound for Resident #88. The facility failed to accurately document skin assessments for a resident with an ankle wound, so the facility and the Wound Doctor had the correct information to conduct wound follow-up and monitoring (Resident #77). The sample was 20. The census was 81. Review of the facility's Wound Management Policy, dated January 2023, showed:-Policy: Manage resident skin integrity through prevention, assessment and implementations and evaluations of interventions.-Procedure:--The facility is provided with Wound Care Protocols. These are to be utilized to assist in the care and treatment of wounds. This reference tool can be placed in the nursing report books;--The facility will use the Braden Scale (clinical tool to assess a patient's risk of developing pressure injuries) for predicting pressure ulcers (localized injuries to skin and underlying tissue, primarily caused by prolonged pressure, friction, or shear, often on bony prominences) on each resident at admission, weekly for four weeks post admission and readmission, and quarterly thereafter to assess skin breakdown risk. Complete the Braden Scale in its entirety in the electronic medical record to calculate a score;--Residents identified at risk on the Braden Scale will have this addressed on their care plan and will have interventions put in place for preventative measure. High risk or any stage pressure injury will have skin checks daily. All others will have at least a weekly skin check assigned through the Resident Scheduler and documented by the nurse Registered Nurse (RN) or License Practical Nurse (LPN). Interventions: Pressure reducing mattress and/or cushion, be reviewed by dietician and lab values as needed. Residents identified with impaired skin will have a care plan initiated regarding impaired skin integrity;--The facility will assess all residents weekly for current skin conditions;---Any resident that scores very high risk, high risk, or has a pressure injury present will have a skin check documented daily to identify any new or worsened areas;---The daily skin assessment will be documented on the electronic treatment administration (eTAR)record/electronic medication administration record , (eMAR), which is completed as follows:----Observe the skin for the following: Clear, Redness, Open, Pressure, and Skin Tear (CROPS);---The nurse responsible for treatments will review all daily documentation and review any new areas;--All wounds will be reported weekly in the eMAR, using wound management;--It is important that wounds are assessed correctly to differentiate between pressure and non-pressure wounds, and documented within wound management;-- It is the responsibility of the Administrator to review the Pressure Wound Report and Non Pressure Injury Report weekly;--Physician and guardian/family members are called weekly with an update of the current wound conditions. 1. Review of Resident's #88's medical record, showed diagnoses included: Open wound right foot, pressure ulcer-coccyx (tailbone), stroke, hemiplegia (weakness limited movement) and hemiparesis (near total paralysis), dysphagia (difficulty swallowing), severe protein - calorie malnutrition (a critical deficiency in protein intake-often coupled with inadequate caloric consumption), cognitive communication deficit (impaired communication), seizure (abnormal electrical activity in the brain) and peripheral vascular disease (PVD) (ineffective blood flow). Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 10/27/25, showed:-admission date 4/5/25;-admission weight 104 pound (lbs.);-Cognitively intact;-Dependent assistance required for activities of daily living (ADLs);-No skin concerns. Review for the resident's care plan, in use during survey, showed no problems related to skin, goals to meet or interventions to prevent wounds. Review of the readmission skin observation report, dated 12/07/25 at 5:02 P.M., showed no skin abnormalities noted. Review of the Nurse Practitioners (NP) progress note dated 12/11/25 at 12:16 P.M., showed new open area to right ankle, no redness or (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	swelling noted. New orders for cleanse right ankle with wound cleaner, pat dry and apply Medi honey (antibacterial, and used for treating chronic and acute wound) to the wound bed. Review of the resident's physician order sheets (POS), showed an order, dated 12/11/25, for Medi Honey gel 80% dime size topical (on the skin), instructions cleanse right buttocks with wound cleanser or normal saline and apply Medi honey and dry dressing (DD) daily until healed 7:00 A.M. - 7:00 P.M. Review of the Resident's MAR/TARs dated 12/25 showed no orders for a right ankle wound treatment. Review of the LPN K weekly skin observation report at 1:41 P.M., dated 12/15/25 showed areas of skin concern: Pressure injury, blister or open area, was checked yes, description buttocks. Review of the NP progress note dated 12/18/25, showed, According to nurse the resident has a right buttocks slight excoriation. NP wrote to continue to monitor area. Review of the Director of Nursing's (DON) skin observation report dated 12/23/25 at 1:28 P.M., showed, no abnormalities of the skin. Review of the LPN J's unscheduled skin observation report dated 12/23/25 at 8:30 P.M., showed skin assessment of right hip abrasion and a coccyx wound previously noted. Review of the Medical Doctor's wound report notes dated 12/30/25, showed:-Activate initial phase of treatment to buttocks, wound type moisture associated skin damage (MASD), no measurements, minimal exudate (mass and fluid), serous (clear/serum) drainage, and signs and symptoms of infection were erythema (red) and warm.-Order for Medi honey to open areas (location of open area not noted), zinc oxide (medicated barrier cream) to peri (around) wound, dry clean dressing (DCD), change daily and as needed (PRN), perform on day shift and PRN;-Right hip pressure injury stage 3 (full thickness and depth to subcutaneous tissue), measurements 3 centimeters (cm) length by 1 cm width by 0.2 cm depth, 50% granulation (new tissue growth) and 50% slough (dead tissue near wound); with moderate exudate drainage serosanguineous (bloody and clear serum);-New order for cleanse, pat dry and apply Medi honey to wound base (location of wound not noted) alginate (highly absorbent dressing), DCD daily and PRN every day and PRN;-Follow up at next appointment. Review of the DON's progress note dated 12/31/25 at 1:47 P.M., (recorded as a late entry on 1/5/26 at 4:59 P.M.) showed right buttock/hip stage 3 ulcer/MASD, measurements of 3 cm by 1 cm, edges are approximated, improving slightly, pink in color, appears to have superficial skin healing since edges have pink wound bed;-Family updated. Review of the resident's MAR/TAR dated January 2026, showed: -Order dated 12/7/25, Medi honey gel 80% cleanse right buttock wound cleaner, or Normal Saline (NS, sterile water), apply Medi honey, DD daily until healed;--Missed four out 31 opportunities, for refused or not completed, without progress notes.-Order dated 1/6/26 cleanse wound right hip with Dura Wound Cleanser (DWC, a general wound care product), pat dry, apply silicone faced foam dressing, change daily;--Per documentation, resident refused 1/8/26, 1/12/26 and 1/18/26 without progress note;--On 1/16/26, missed dressing change without a progress note. Review of the Medical Doctor's wound report notes dated 1/6/26, showed:-Wound onset date 12/30/25, buttocks MASD, healing, drainage exudate serous and signs symptoms of erythema and warmness;-Treatment order: Medi honey to open areas zinc oxide per wound DCD, daily and PRN every day and PRN;-Wound onset date 12/30/25, Right hip wound stage 3 declined, related wound status - dressing changes and offloading, measurements 4 cm by 1.5 cm by 0.3 cm 60% granulation and 40% slough;-Treatment order: Consult physical therapy and occupational therapy for wound offloading needs to right lower extremity. Review of the DON's progress note, dated 1/6/26 at 4:49 P.M., showed:-This is a wound note;-Right buttocks MASD, 0.5 cm by 0.5 cm edges approximated, significant improvement from last week, pink in color, appears to have superficial skin healing since edges have pink wound bed;-Right hip, 4.1 cm by 1.5 cm by 0.3 cm, appears stable, pink wound bed, wound edges approximated;-Family updated. Review of the DON's progress note, dated 1/16/26 at 11:14 A.M., showed:-This is a wound note;-Right buttock MASD - healed;-Right hip pressure injury stage 3, measurements were 3.6 by 1.2 cm by 0.1 cm, improved pink wound bed, wound edges approximated;-Family updated and medical doctor updated. Review of the DON's progress note dated 1/23/26 at 12:53 A.M., showed:-This is a wound note;-Right buttock MASD - healed;-Right hip stage 3, 3.6 cm by 1.2 cm by 0.1 cm, improved pink wound bed, wound edges (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	approximated;-Family updated and medical doctor updated. Review of the Medical Doctor's wound report dated 1/27/26, showed:-Onset date 12/30/25, sacrum (tailbone), wound type buttocks, posterior scrotum healing status, declined, minimal exudate with serous drainage and signs and symptoms of infection erythema;-Patient unable to offload,-Other--peri-care (incontinence care) and relative immobility;-Treatment order: Zinc oxide to peri wound, DCD daily and PRN with incontinence, every day and PRN;-Onset wound date 12/30/25, right hip, wound type pressure injury, stage 3 healing type, stable/same, measurements 4.5 cm by 1.0 cm by 0.3 cm, 40% granulation and 60% slough; moderate serosanguineous drainage signs and symptoms of infection purulence (discharging pus, typically indicating a bacterial infection);-Treatment order: Cleanse, pat dry, Medi honey to wound bed (location of wound not noted), alginate with silver (highly absorbent, sterile, antimicrobial wound dressings derived) DCD daily and PRN, every day and PRN. Review of the DON's progress note dated 1/30/26 at 4:54 A.M., showed:-This is a wound note;-Sacral buttock MASD - 4.8 cm by 6.3 cm, stable pink wound bed, wound edges approximated;-Right hip, stage 3, 4.5 cm by 1.0 cm by 0.3 cm, improved pink wound bed, wound edges approximated;-Scrotum MASD, 2 cm by 1.0 cm by 0.1 cm, stable, very superficial;-Family updated. Review of the resident's MAR/TAR dated February 2026, showed: -Order date 3/11/25, barrier cream to applied to resident's peri area (area between the thighs, extending from the pubic bone to tail bone) after each incontinence episode every shift, missed eight out of 42 opportunities;-Order date 11/3/25, apply zinc oxide to buttocks, cleanse with soap and water, pat dry PRN and following each incontinence episode, missed 66 out of 66 opportunities;-Order date 12/11/25, Medi Honey, right buttocks with normal saline or wound cleanser, apply Medi honey and dry dressing daily until healed, missed six times out of 23 opportunities;-Order date 1/6/26, cleanse wound to right hip with DWC, pat dry, apply silicone face foam dressing, change daily once daily, missed six times out of 22 opportunities, without any progress note;-Order date 2/11/26, for cleanse right ankle with wound cleanser, pat dry, apply Medi Honey dime size amount to the wound (location of wound not noted) and cover with dry dressing daily every shift, missed 10 times out of 30 opportunities. Review of the DON's progress note dated 2/6/26 at 4:34 P.M., showed:-This is a wound note;-Sacral buttock MASD - 4.8 cm by 6.3 cm, stable pink wound bed, wound edges approximated, no change from previous week;-Right hip, stage 3, 4.5 cm by 1.0 cm by 0.3 cm, slight decline, pink wound bed, wound edges approximated, no change from last week;-Scrotum MASD, 2 cm by 1.0 cm by 0.1 cm, stable, very superficial;-Family updated. Review of the Medical Doctor's wound report dated 2/10/26, showed:-Resident was away from facility not seen by doctor.Review of the DON's progress note dated 2/11/26 at 10:29 A.M., showed;-The resident had a new wound to his/her ankle and the NP confirmed the resident did not appear to be ill or need to be sent to hospital for evaluation. NP suggested to keep the same treatment as the wound doctor planned. Review of the DON's progress note dated 2/13/26 at 10:43 A.M., showed:-This is a wound note;-Sacral/coccyx buttock MASD - 4.8 cm by 6.3 cm, stable pink wound bed, wound edges approximated, no change from previous week;-Right hip, stage 3, 4.5 cm by 1.0 cm by 0.3 cm, stable, pink wound bed, wound edges approximated, no change from last week;-Scrotum MASD, 2 cm by 1.0 cm by 0.1 cm, stable very superficial;-Right ankle/foot, stage 2 ulcer (a partial-thickness tissues loss), 2 cm by 2 cm by 0.1 cm, stable, wound edges approximated;-Family updated. Review of the Medical Doctor's wound report, dated 2/17/26 with an addendum 2/23/26 showed:-Onset wound 12/30/25, right hip, stage 3 pressure injury, stable, measurements were 4.5 cm by 1.0 cm by 0.3 cm, moderate serosanguineous drainage, signs and symptoms of infections purulence;-Treatment orders: Pat dry, Medi honey to wound base alginate with silver DCD, daily and PRN;-Comments: Wound status not able to assess today, patient was seen and found very lethargic. The vitals were collected by the DON and me while rounding. The resident was given Naloxone (Narcan treats overdoses) resident sent out to local hospital. Review of the resident's census log showed that he/she discharged from the facility at 2:45 P.M., on 2/27/26 without anticipated return. Review of the facility's wound report dated 3/27/26, showed:-Onset of 12/11/25, right buttocks, wound type MASD on 12/11/25, not (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	present on admission open wound for 36 days improving as of 1/6/26;-Onset of 1/20/26, coccyx, wound type MASD, not present on admission, wound 49 days open and stable as of 3/13/26;--Onset of 1/20/26, groin, wound type MASD, not present on admission, wound has been open for 49 days, stable as of 3/13/26. During an interview on 3/27/26 at 7:26, LPN K said last time he/she saw the resident, he/she had a hip, coccyx and possible ankle wound. All residents have standing orders for skin assessments and are care planned for any refusal of treatments. LPN K said the resident was one who had to be approached a couple of times before he/she would do something. The resident did like to smoke and would not do anything if it was smoke break time. LPN K said the resident was understanding of the need to off-load his/her weight for wound treatments. 2. Review of Resident's #77's medical record, showed diagnoses included morbid obesity, bipolar (mood swings), intellectual disability (neurological disability). Review of the resident's annual MDS, dated [DATE], showed:-admission date of 7/9/24;-Moderately impaired cognition;-Full dependence on staff assistance for ADLs;-No skin concerns noted. Review of the resident's care plan, in use during survey, showed no problems related to skin, goals to meet or interventions to prevent wounds. Review of the Braden Scale report predicting pressure sore dated 12/17/25 at 6:24 A.M., showed a score of 11 (indicated the resident is at a high risk for developing a pressure injury). Review of the resident's POS, dated December 2025, showed: -Offload pressure areas (on heels), keep area of concern and surrounding skin dry, elevate extremities every shift 7:00 A.M., -7:00 P.M., and night (NOC) 7:00 P.M., - 7:00 A.M.,-Order dated 12/15/25 showed, cleanse lateral right ankle with normal saline or wound cleanser, pat dry and apply foam dressing every three days, start at 6:00 A.M. Review of the of Wound Specialist's progress note, dated 12/17/25, showed patient not seen, resident away from facility with family. Review of the of Wound Specialist's progress note, dated 12/30/25, showed patient not seen, DON said the right ankle wound healed. Review of the weekly skin observation report form, dated 3/3/26 at 7:27 A.M., showed no abnormalities of the skin present. Review of the weekly skin observation report form, dated 3/17/26 at 7:41 A.M., showed no abnormalities of the skin present. Review of the resident's March 2026 MAR/TAR, showed:-An order dated 12/15/25, cleanse right lateral ankle with normal saline or wound cleanser, pat dry, apply foam dressing every three days:--Documented as completed on 3/3, 3/6, 3/9 and 3/12/26;--On 3/15/26, documented as not administered, other comment;--On 3/18/26, documented as resident refused;--On 3/21/26, documented as resident refused;--On 3/24/26, documented as resident combative, will attempt this evening. Observations on 3/25/26 at 8:04 A.M., showed the resident had a foam dressing on his/her right ankle with a date of 3/9. The resident's heels were on pillows directly under the heels. His/Her left inner heel had a dark circular discoloration, the size of a quarter. During an interview on 03/25/2026 at 8:30 A.M., LPN K said the dressing on the resident's right ankle was dated for 3/9. The orders were for a standard dry dressing, and night shift were scheduled to change the wound. LPN K will go check the ePOS now and clean the wound, along with notifying the Wound Doctor. LPN K checked the computer and said the resident was listed as refused care from 3/9 to 3/25/26 at 8:52 A.M. LPN K was unaware of the wound and staff had not mentioned it in shift report. The wound measured 2 cm by 2 cm. During an interview on 3/25/26 at 8:41 A.M., the DON said there was some discoloration to the left heel, equivalent to the size of a dime. The DON said he is not at liberty to make any clinical decisions related to the stage or type of wound without first a consultation with the Wound Doctor. The Wound Doctor makes all those clinical decisions. Review of the of Wound Specialist's progress note, dated 3/25/26, showed:-Onset wound date 3/25/26, stage 2 pressure injury over right ankle, measurements are 0.5 cm by 1.5 cm by 0.1 cm, moderate serous drainage, no signs or symptoms of infection;-Treatment order: Cleanse wound with NS or sterile water, apply alginate to wound bed, cover with dry clean dressing. Review of the of NP's progress note, dated 3/25/26 at 7:20 A.M., showed the resident has a stage 2 pressure injury, per Wound Doctors' notes, It's very shallow with good granulation tissue, which is a good sign of healing from changes with moderate amount of serous drainage, no signs or symptoms of infection, no foul odor, pain, noticed at (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the time of dressing change. During an interview on 3/27/26 at 10:09 A.M., the DON said the resident's wound to the right ankle was an abrasion, but he would need to review the entry; this could be a clinical error. Review of the facility's wound report dated 3/27/26 showed the resident has a right ankle abrasion, initial measurements were 3 cm by 2 cm, current are 0.5 cm by 1.5 cm, improving. 3. During an interview on 3/27/26 at 12:20 P.M., the DON said he expected nursing staff to follow facility policies. Assessments were completed weekly, but there were not orders for them. Staff are prompted on the schedule on the EMR. The shift nurses are expected to enter the treatment orders, or the nurse can provide the DON the order to enter in on their behalf. The DON expected nurses to enter a progress note related to treatments being declined by residents. Staff should also notify the Medical Doctor of any new recommendation from the hospital related to wound treatments. All care plans should be updated by the MDS coordinator within 24-48 hours to reflect new changes for the resident. If the resident declines a treatment, staff should try a second approach or allow some time to lapse before documenting a refusal. 274163127417612742276

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F 0689 Level of Harm - Minimal harm or potential for 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 implement fall interventions for one resident with frequent falls (Resident #26) and failed to ensure one resident was assessed for safety while smoking (Resident #15). The sample was 20. The census was 81. Review of the facility's Fall Management policy, dated 3/28/25, showed:-Policy: It is the policy of the management company to assess and manage resident falls through prevention, investigation, and implementation and evaluation of interventions;-Procedure: A fall risk assessment will be completed on all residents upon admission, re-admission, after each fall and quarterly thereafter. Residents identified as high risk will have fall prevention addressed on the plan of care. Review of the facility's Smoking policy, dated 10/21/22, showed:-Purpose: To ensure all residents are safe while smoking;-Procedure: Any resident that expresses an interest in smoking will be assessed at the time of admission and at least quarterly or with any significant change to determine the level of assistance and supervision that will be needed to ensure the resident's safety;-Residents who are determined by the care plan team to be able to smoke withoutsupervision may smoke at will in the designated smoking area. Smoking materials will be returned to the nurse's station and will not be kept in the resident's room. The facility will notify the resident of the times throughout the day that independent smoking is allowed;-All residents that are not deemed capable of smoking unsupervised, will be given the opportunity to smoke with supervision at the designated facility smoking times. All smoking supplies for residents that require supervision will be kept at the nurse's stations when not in use. 1. Review of Resident #26's admission Minimum Data Set (MDS), a federally mandated assessment instrument competed by facility staff, dated 12/23/25, showed:-Lower extremity impairment to one side;-Partial to moderate assistance required for transfers;-Diagnoses included diabetes, acute kidney failure, and acquired absence of right leg above the knee. Review of the resident's care plan, in use at the time of the survey, showed:-Focus: Resident admitted to the facility for long term care. Resident requires a baseline care plan identifying care needs, risks, strengths and goals within the first 48 hours;-Goal: Resident will have access to necessary services to promote adjustment to new living environment in the facility;-Approaches: Resident will need to be monitored to prevent falling in new environment. Resident will need assistance with bed/chair mobility, assistance with transfers, assistance with locomotion to prevent falling or injury. Resident uses a wheelchair and need safety reminders to use durable medical equipment safely;-The care plan did not address the resident's falls or any fall interventions put in place. Review on 3/23/26, of the facility's facility event summary report, dated 12/23/25 through 3/23/26, showed:-On 12/24/25 at 6:42 P.M, the resident had an unwitnessed fall;-On 1/6/26 at 7:25 A.M., the resident had an unwitnessed fall;-On 1/11/26 at 4:00 A.M., the resident had an unwitnessed fall;-On 1/29/26 at 11:11 A.M., the resident had a witnessed fall;-On 1/29/26 at 12:32 P.M., the resident had a witnessed fall;-On 2/17/26 at 11:40 A.M., the resident had an unwitnessed fall. Review of the resident's fall investigation, dated 2/28/26, showed:-Event information: Resident had an unwitnessed fall in his/her bathroom;-Root cause: Resident left dining area and tried to transfer from wheelchair to toilet in common bathroom. Resident encouraged to ask for assistance;-No new interventions documented. Review the resident's fall investigation, dated 3/14/26, showed:-Event information: Resident had a witnessed fall in his/her bathroom;-Root cause: Resident was trying to transfer him/herself from bed to wheelchair without assistance;-No new interventions documented. Review of the resident's fall investigation, dated 3/19/26, showed:-Event information: Resident had unwitnessed fall in his/her room;-Root cause: Resident had an amputated leg and tried to get out of bed without assistance and into wheelchair. Resident educated on calling for help when wanting to move;-No new interventions documented. Observation on 3/25/26 at 6:47 A.M., showed the resident seated in his/her wheelchair by the left side of his/her bed with eyes (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	closed. The call light not in reach. Observations on 3/26/26 at 6:51 A.M., 7:46 A.M., 9:36 A.M., 9:54 A.M., and 11:08 A.M., showed the resident seated in a wheelchair to the left side of his/her bed, with eyes closed. The call light not in reach, on the ground on the right side of the resident's bed. During an interview on 3/26/26 at 10:52 A.M., the Director of Therapy said the resident is receiving physical therapy, occupational therapy and speech therapy. Her recommendation for the resident is that he/she should be in a wedge wheelchair (tilted wheelchair) with foot pedals to prevent further falls. She expected the resident's call light to be in reach at all times. She expected nursing staff to conduct more frequent rounding on the resident. She expected these interventions to be on the resident's care plan. During an interview on 3/27/26 at 7:28 A.M, Licensed Practical Nurse (LPN) C said the resident has had frequent falls. The resident should have fall interventions put in place. His/Her care plan should include interventions that have been put in place. The Director of Nurses (DON) is responsible for updating the care plan. During an interview on 3/27/26 at 12:50 A.M., the Administrator and DON said they have tried many different interventions but nothing has worked to prevent the resident's falls. They have tried frequent rounding, ensuring the call light is in reach of the resident, and having the resident sit where he/she can be observed. Interventions should be documented on a resident's care plan. Interventions should be in place for the resident due to his/her frequent falls. 2. Review of Resident #15's admission MDS, dated [DATE], showed:-Diagnoses included Huntington's disease (neurodegenerative disorder) and weakness;-Moderately impaired cognition. Review of the resident's electronic medical record, reviewed 3/24/26 at 12:00 P.M., showed no smoking assessment. Observations on 3/25/26 at 1:25 P.M. and 3/26/26 at 8:12 A.M., showed the resident outside smoking. During an interview on 3/27/26 at 7:28 A.M., LPN C said staff should have completed as smoking assessment on the resident upon his/her admission. Completion of a smoking assessment is important to ensure the resident's safety while smoking. During an interview on 3/27/26 at 12:30 P.M., the Administrator and DON said they expected for staff to have completed a smoking assessment on the resident upon admission. 2741631