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	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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure facility staff used proper hand hygiene during meal service affecting seven Residents (Residents #54, #2, #47, #25, #29, #26, and #30) and failed to ensure hair restraints were worn properly while handling food in the kitchen. The sample size was 20. The census was 81. Review of the facility's handwashing policy, dated 1/2012, showed:-Policy: Handwashing facilities will be readily accessible and equipped with paper towels and soap. Staff will wash hands frequently as needed throughout the day following proper handwashing procedure;-Procedure: When to wash hands; after touching ears, nose, mouth, hair, etc. Any contact with infected or otherwise unsanitary areas of the body. Hand contact with unclean equipment or work surfaces. Hand contact with soiled clothing or other materials that are soiled. Review of the facility's personal hygiene and appearance policy, dated 1/2012, showed:-Purpose: To ensure a clean and proper uniform appearance consistent with good personal hygiene. To ensure staff are in good health to support food safety and environmental safety goals. To support food safety practices and to maintain compliance with federal, state and local regulations governing food safety;-Policy: Staff shall report to work in clean uniforms according to the facility uniform policy. Hair nets or hair coverings shall be worn while in the kitchen or storage areas. Facial hair shall be covered with a beard cover. 1. Review of Resident #54's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/9/26, showed:-Diagnoses included chronic kidney disease, type two diabetes, and unspecified intellectual disabilities;-Cognitively intact. 2. Review of Resident #2's quarterly MDS, dated [DATE], showed:-Diagnoses included end stage renal disease, legal blindness, dementia, and major depressive disorder;-Moderately impaired cognition. 3. Review of Resident #47's quarterly MDS, dated [DATE], showed:-Diagnoses included chronic respiratory failure, dementia, major depressive disorder, chronic kidney disease, and schizoaffective disorder (mental health condition that includes features of both schizophrenia and a mood disorder);-Severe cognitive impairment; 4. Review of Resident #25's quarterly MDS, dated [DATE], showed:-Diagnoses included type two diabetes, major depressive disorder, and anxiety;-Cognitively intact. 5. Review of Resident #29's quarterly MDS, dated [DATE], showed:-Diagnoses included dementia, major depressive disorder, and chronic kidney disease;-Moderately impaired cognition. 6. Review of Resident #26's admission MDS, dated [DATE], showed:-Diagnoses included type two diabetes, acute kidney failure, and acquired absence of right leg above the knee;-Cognitively intact. 7. Review of Resident #30's quarterly MDS, dated [DATE], showed:-Diagnoses included hemiplegia (paralysis) and hemiparesis (weakness) affecting right dominant side and type two diabetes;-Severe cognitive impairment. 8. Observation on 3/23/26, of breakfast in the main dining room, showed:-At 8:45 A.M., Certified Nursing Assistant(CNA) E touched Resident #54, patting him/her on the shoulder, went to the serving line to pick up a food tray, and brought the food tray to Resident #2. He/She picked up Resident #2's silverware and used it to cut up the resident's food;-At 8:49 A.M., CNA E took the empty tray that held Resident #2's food back to the serving line to discard it, grabbed a clean coffee cup, poured a cup of coffee, and brought the coffee (continued on next page)

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	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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	cup to Resident #2;-At 8:51 A.M., CNA E picked up a clean coffee cup, poured coffee in it, and [NAME] the cup to Resident #47; -At 8:53 A.M., CNA E brought cups of coffee to both Resident #25 and #29 who were both seated together. While speaking to CNA B, CNA E touched CNA B's shirt;-At 8:54 A.M., CNA E brought a cup of coffee to Resident #26;-At 8:57 A.M., CNA E put his/her hands in his/her pocket. He/She then walked over to Resident #47 and repositioned him/her in his/her wheelchair while holding onto the resident. CNA E then turned and patted Resident #30 on the shoulder while speaking with him/her. 9. Observations on 3/23/26 at 8:41 A.M., 8:44 A.M., 8:47 A.M., 8:50 A.M., 8:56 A.M., 9:04 P.M., and 9:12 A.M., of breakfast in the main dining room, showed Dietary Aide F in the kitchen preparing plates at the steam table. His/her hair net was on. Approximately 2 inches of hair was hanging out of the hair net around the front of both sides of his/her face. 10. Observations on 3/25/26 at 12:15 P.M., 12:26 P.M., 12:30 P.M., 12:35 P.M., 12:40 P.M., and 12:45 P.M., of lunch in the main dining room, showed Dietary Aide F in the kitchen preparing plates at the steam table. His/her hair net was on. Approximately 2 inches of hair was hanging out of the hair net around the front of both sides of his/her face. 11. During an interview on 3/26/26 at 1:09 P.M., the Dietary Manager said she would expect staff to sanitize their hands after touching any unclean surface, resident, or themselves. She would expect dietary staff to wear hair restraints properly in order to keep hair out of the food. 12. During an interview on 3/27/26 at 12:44 P.M., the Administrator said she would expect staff to sanitize their hands after touching any unclean surface, a resident, or their clothing. She would expect kitchen staff to have their hair restraints on properly to ensure hair does not get into food.

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	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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure six discharged residents had their money returned after discharge within 30 days (Residents #89, #90, #91, #92, #93, and #94), and failed to ensure third party liability (TPL) letters were sent and followed up on to for two residents who expired with balances in their account (Residents #95 and #96). The census was 81. Review of the facility's resident trust policy, undated, showed:-The Business Office Manager(BOM) has the primary responsibility for ensuring that residents' funds held in the trust are kept safe, are properly accounted for, and that all payments from the residents' funds are appropriate and legitimate;-Procedure: discharged /deceased resident accounts need to be refunded to theresident or Medicaid no later than 30 days from date of discharge. 1. Review of Resident #89's resident trust account, showed:-Resident discharged on [DATE];-The account had a balance of $1,644.00;-No record of funds returned to the resident. 2. Review of Resident #90's resident trust account, showed:-Resident discharged on [DATE];-The account had a balance of $378.68;-No record of funds returned to the resident. 3. Review of Resident #91's resident trust account, showed:-Resident discharged on [DATE];-The account had a balance of $60.67;-No record of funds returned to the resident. 4. Review of Resident #92's resident trust account, showed:-Resident discharged on [DATE];-The account had a balance of $3,016.56;-No record of funds returned to the resident. 5. Review of Resident #93's resident trust account, showed:-Resident discharged on [DATE];-The account had a balance of $25.97;-No record of funds returned to the resident. 6. Review of Resident #94's resident trust account, showed:-Resident discharged on [DATE];-The account had a balance of $30.00;-No record of funds returned to the resident. 7. Review of Resident #96's resident trust account, showed:-Resident expired on [DATE];-The account had a balance of $.03;-No record of TPL letter being sent. 8. Review of Resident #95's resident trust account, showed:-Resident expired on [DATE];-The account had a balance of $717.45;-No record of TPL letter being sent. During an interview on [DATE] at 1:57 P.M., the BOM said he would expect money to be out of the resident's accounts in the required time frame when they discharged or expired. He did not know the exact timeframe. He said he did not send the TPL letters and that the corporate office sent them out. He did not have proof that the TPL letters were sent. During an interview on [DATE] at 12:53 P.M., the Administrator said she would expect for the facility policy to be followed for resident funds. She would expect the TPL letters to be sent when a resident expired. She would expect resident funds to be returned to Medicaid or to the resident following their discharge within 30 days.

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	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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure common areas in the facility were maintained in a clean, comfortable and homelike environment. Concerns were identified with two of 20 sampled residents (Resident #45 and #39), the Memory Care Courtyard and resident hall shower rooms on the 100, 200 and 300 halls. The census was 81.1. Review of the facility's Night Shift Assignment Sheet, undated, showed wheelchairs should be cleaned nightly. 2. Review of the facility's housekeeping cleaning schedule for March of 2026, showed shower rooms on all resident halls were to be cleaned once weekly on Sundays. 3. Review of Resident #45's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated, 3/9/26, showed:-Diagnoses included depression and schizophrenia (a mental disorder that distorts reality);-The resident uses a wheelchair. Observation on 3/23/26 at 6:20 A.M., 3/25/26 at 9:25 A.M., and 3/27/26 at 10:30 A.M., showed the resident sat in his/her wheelchair in the Memory Care dining room. The resident's wheelchair had a white powdery substance, dust and hair on the wheelchair frame and wheels. 4.Review of the Resident #39's annual MDS, dated [DATE], showed:-Diagnoses included diabetes and bipolar disorder (a mental disorder that cause severe mood swings);-The resident uses a wheelchair. Observation on 3/23/26 at 6:20 A.M. and 3/24/26 at 12:17 P.M., and 3/25/26 at 9:22 A.M., showed the residents sat in his/her wheelchair in the Memory Care dining room. The resident's wheelchair had a thick layer of dust and food particles on the wheelchair frame and wheels. During an interview on 3/26/26 at 10:45 A.M., Licensed Practical Nurse (LPN) L said the night shift was to wipe down and clean the residents' wheelchairs weekly. He/She was not aware of a set schedule but though it might be on the resident shower days that the wheelchairs were to be cleaned. During an interview on 3/27/26 at 12:22 P.M., the Assistant Director of Nursing (ADON) said the resident wheelchairs were expected to be cleaned by nursing staff on the night shift and the staff had not been doing it. 5. Observation on 3/24/26 at 4:15 P.M. and 3/26/26 at 10:45 A.M., of the Memory Care Courtyard showed, an overgrowth of weeds, cigarette butts, dandelions, overgrown grass, piles of leaves near the entrance of the courtyard and two animal traps with weeds growing over them. The windows were covered with dirt, dust and spiderwebs. Observation on 3/25/26 at 1:40 P.M., showed four residents sat in the Memory Care Courtyard smoking with two facility staff members. The courtyard showed an overgrown of weeds, cigarette butts, dandelions, overgrown grass, piles of leaves near the entrance of the courtyard and two animal traps with weeds growing over them. The windows were covered with dirt, dust and spiderwebs. During an interview on 3/24/26 at 12:17 P.M., Certified Medicine Technician (CMT) M and Activities Assistant O said the residents go into the courtyard for activities and to smoke. The courtyard has not been cleaned for several months, and they never saw anyone clean the windows. The residents looked out onto the courtyard during meals or watching television and the courtyard was not in the best shape and could use some work. During an interview on 3/26/26 at 10:45 A.M., the Maintenance Director said he was responsible for maintaining the Memory Care Courtyard and had not cleaned anything in the courtyard since last year. He had not done any type of fall or winter maintenance or cleaning. The animal traps were for when they use to have racoons, and they were trying to trap them. He said the courtyard did need some cleanup work so it would look better for the residents. During an interview on 3/26/26 at 10:47 A.M., the Housekeeping Supervisor said she was new and did not know who cleaned the outside of the windows and said they were very dirty and did need to be washed. The Memory Care Courtyard did not appear to be very homelike with the condition it was in. 6. Observation on 3/23/26 at 5:50 A.M. of the facility's 100 hall shower room, showed what appeared to be excrement on the walls and baseboards near the shower room toilet, and the whirlpool tub filled with packages of incontinence briefs and a soft positioning wedge. A pile of dirty, unmarked clothes and a plastic bag filled with (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	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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	toiletries was observed on a chair near the shower stall. Observation on 3/23/26 at 6:20 A.M. of the facility's 200 hall shower room, showed the room's whirlpool tub filled with packages of briefs, linens, and a soft positioning wedge. A laundry cart was observed blocking access to the toilet stall. Observation on 3/23/26 at 6:41 A.M. of the facility's 300 hall shower room, showed the room's whirlpool tub filled with packages of briefs. A pile of wet towels and a wet chucks pad were observed on the floor of the shower room, a pair of latex gloves and a comb were observed on the floor under the sink, and a pair of wheelchairs blocked entrance to the room's shower stall. Observation on 3/24/26 at 11:03 A.M. of the facility's 200 hall shower room, showed the room's whirlpool tub filled with packages of briefs, linens, and a soft positioning wedge. Two large trash cans and two laundry carts were parked inside the door to the shower room, blocking access to any part of the shower room. Observation on 3/24/26 at 11:11 A.M. of the facility's 100 hall shower room, showed what appeared to be excrement on the walls and baseboards near the shower room toilet, and the whirlpool tub filled with packages of incontinence briefs and a soft positioning wedge. A pile of dirty, unmarked clothes and a plastic bag filled with toiletries was observed on a chair near the shower stall. Observation on 3/25/26 at 8:23 A.M. of the facility's 200 hall shower room, showed the room's whirlpool tub filled with packages of briefs, linens, and a soft positioning wedge. Two large trash cans and two laundry carts were parked inside the door to the shower room, blocking access to any part of the shower room. Observation on 3/23/26 at 8:25 A.M. of the facility's 300 hall shower room, showed the room's whirlpool tub filled with packages of briefs. A pile of wet towels and a wet chucks pad were observed on the floor of the shower room. The toilet appeared to be clogged with excrement and toilet paper. Observation on 3/24/26 at 8:27 A.M. of the facility's 100 hall shower room, showed what appeared to be excrement on the walls and baseboards near the shower room toilet, and the whirlpool tub filled with packages of incontinence briefs and a soft positioning wedge. A pile of dirty, unmarked clothes and a plastic bag filled with toiletries was observed on a chair near the shower stall. 7. During an interview on 3/27/26 at 8:03 A.M., Housekeeping Aide G said housekeeping staff were responsible for cleaning the resident hall shower rooms every day, which could sometimes be made much more difficult when the shower rooms were filled with trash cans, laundry carts, or mechanical lifts. Wheelchairs in the facility were cleaned nightly by nursing staff, and was not the responsibility of the housekeeping staff. During an interview on 3/27/26 at 8:09 A.M., LPN C said resident hall shower rooms were the responsibility of the housekeeping staff and should be cleaned every day. Wheelchairs were cleaned by night shift nursing staff on a routine basis, but anyone could clean a resident's wheelchair if requested or needed. During an interview on 3/27/26 at 8:26 A.M., CNA H said resident hall shower rooms should be cleaned after every resident shower by the staff who used the shower room to care for the resident. The shower rooms were deep cleaned on a routine basis by the housekeeping staff, but CNA H was unsure of which day of the week deep cleaning was done. Wheelchairs could be cleaned by anyone when requested by a resident and were routinely cleaned by the night shift nursing staff. During an interview on 3/27/26 at 12:21 P.M., the facility Administrator, Director of Nursing (DON) and Assistant Director of Nursing (ADON) said housekeeping staff were responsible for deep cleaning resident hall shower rooms once weekly, and nursing staff should clean them after resident use. Wheelchairs were cleaned by night shift nursing or as requested by a resident. The facility maintenance staff was responsible for the memory care courtyard and should ensure the courtyard was maintained in a clean manner and any animal traps were routinely surveilled for activity and/or removal.

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	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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to have a system in place to ensure controlled medications were securely stored under two locks for one out of one medication room observed. The facility also failed to label eye drops with an open and expiration date for two out of four medication carts reviewed. The census was 81. Review of the facility's Medication Administration policy, dated [DATE], showed:-Policy: Medications and biologicals are stored safely, securely, and properly following the manufacturer or supplier recommendations;-All drugs classified as a controlled substance will be stored under double locks;-The policy did not address labeling of eye drops. 1.Observation and interview on [DATE] at 10:05 A.M. of the Central Medication Room, showed a refrigerator with no lock. Inside the refrigerator showed 56 vials of Lorazepam (a controlled substance medication used to treat anxiety) 2 milligrams (mgs) per milliliter (ml) not secure in a locked container. The Lorazepam vials expired [DATE]. Registered Nurse (RN) Q said he/she did not know the medication was in the refrigerator because it was not being counted. The Lorazepam should have been secured in a locked box in the refrigerator. During an interview on [DATE] at 12:22 P.M. the Director of Nurses (DON) and the Assistant Director of Nurses (ADON) said once the medication was discontinued or expired, it should be immediately brought to the DON's office so it could be destroyed. The Lorazepam was expected to be secured under two locks. 2.Observation and interview on [DATE] at 8:53 A.M. of the 100 and 400 hall medication cart, showed:-Two bottles of Dorzolamide-Timolol 2%/0.5% (eye medication use to treat high eye pressures), with the manufacturer seal broken, no open date or expiration date;-One bottle of Ciprofloxin 0.3 % eye drops (eye medication used to treat eye infections) with the manufacturer seal broken, no open date or expiration date;-One bottle of Tobramycin 0.3 % eye drops (eye medication used to treat eye infections) with the manufacturer seal broken, no open date or expiration date;-One bottle of Asteline 0.5 % eye drops (eye medication use to treat itching) with the manufacturer seal broken, no open date or expiration date;-One bottle of Brimonidine 0.2 % eye drops (eye medication use to treat high eye pressures) with the manufacturer seal broken, no open date or expiration date;-RN Q said the eye drops should be labeled when opened and with an expiration date to ensure the efficacy of the medications. RN Q was not sure how long the eye drops lasted after they were opened, but thought it was 30 days. 3.Observation and interview on [DATE] at 9:25 A.M. of the Memory Care Certified Medication Technician (CMT) Cart, showed one bottle of Cipro 0.3 % eye drops with the manufacturer seal broken, no open date or expiration date. CMT M said whoever opens the eye drops should label them with the open date and expirations date. Eye drops once opened were good for 30 days. The labeling of eye drops was important because expired eye drops should not be given to the residents. During an interview on [DATE] at 12:22 P.M., the DON and ADON said they expected staff to label eye drops with an open date and an expiration date to ensure the efficacy of the eye medications. Recommendations of when medications expire were based off pharmacy instructions.

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	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to follow enhanced barrier precautions (EBP, precautions for use during high-contact resident care activities for residents infected with a multidrug-resistant organism (MDRO, microorganisms that are resistant to one or more classes of antimicrobial agents) or any resident who has a chronic wound and/or indwelling medical device) during care and failed to follow acceptable infection control practices during wound care, medication administration and direct patient care related to hygiene, for three of three residents observed for wound care (Residents #5, #26 and #77). The facility also failed to follow acceptable infection control practices during blood glucose testing. In addition, staff failed to ensure one out of five residents sampled for vaccinations and health screenings had a two-step tuberculosis (TB, infectious lung disease) screening within the 30-day post admission, per facility policy (Resident #49). The sample was 20. The census was 81. Review of the facility's Infection Prevention and Control Program Policies and Procedures, dated August/2018, showed: -The organization has made a commitment to prudent infection prevention and control measures by prompting the concept of compassionate, common-sense resident and patient care, with an emphasis on cleanliness and infection prevention strategies. This organization has an established infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. We strive to implement evidence based approaches to infection prevention; -The infection prevention and control program: --Investigates, controls, prevents infection in the organization; --Decides what procedures, such as isolation, should be applied to the individual resident/patient; --Maintains a record of incident and corrective actions related to infections; --Has written procedures as a basis of determination for isolation (transmission based precautions) to help prevent the spread of infection; Review of the facility's Isolation Precautions/EBP policy, dated 4/24, showed: Policy: It is the policy to make every effort to prevent the spread of infection in the facility;--Standard Precautions require the health care worker (HCW) to estimate the degree of risk associated with a given task and plan for appropriate personal protective equipment; --Precautions and expand the use of Personal Protective Equipment (PPE) to donning of gown and gloves during high contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing; Procedurep (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	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-EBP will be used for any resident who meets the following criteria:- Infection or colonization with a Center for Disease Control & Prevention (CDC_-targeted MDRO when contact precautions do not otherwise apply;-Chronic wounds, such as, pressure ulcer, venous stasis ulcers, diabetic ulcers, unhealed surgical wounds;-Indwelling medical devices, such as, central lines, urinary catheters, feeding tubes, and tracheostomies. -Residents who meet the above criteria, EBP are recommended when performing the following high-contact resident care activities:--Providing hygiene;--Changing briefs or assisting with toileting;--Chronic wound care; - Place EBP sign at entrance to the room for the residents who meet the criteria; --Staff will clean their hands before entering and when leaving the room;--Staff will wear gloves and a gown for high-contact resident care activities;--Do not wear the same gloves and gown for the care of more than one person;--If only one resident in the room requires EBP, place an EBP sign above the bed of the resident who meets the criteria as well as the entrance to the room. 1. Review of Resident #5's medical record, showed: -Diagnoses included gastrostomy tube (g-tube, a tube that is surgically inserted into the abdomen to administer medication and liquid nutrition) and Alzheimer's disease; -An order, dated 10/22/25, levetiracetam (medication used to treat seizures) give 100 milligrams (mgs) via g-tube; -An order, dated 10/16/25, polyethylene glycol (medication used to treat constipation) give 17 grams (gms), via g-tube; -No order for enhance barrier precautions. Review of the resident's care plan, in use at the time of survey, showed it did not address EBP. Observation on 3/25/26 at 8:53 A.M., showed Registered Nurse (RN) Q prepared the resident's medication at the medication cart and entered the resident's room. A PPE supply drawer was located outside the resident's room. The resident had an EBP sign posted on the door and above his/her bed on the wall. RN Q moved the resident's arms away to obtain access to the resident's g-tube. The resident held onto the RN Q's arm. RN Q administered the levetiracetam and polyethylene glycol through the residents g-tube with gloved hands. RN Q did not wear an isolation gown while administering medications. During an interview on 3/25/26 at approximately 9:00 A.M., RN Q said he/she should have worn an isolation gown when administering the resident's medications. EBP should be worn when staff is providing direct care to a resident who has wounds, g-tubes, dialysis ports and urinary catheters 2. Review of Resident #26's medical record, showed: -Diagnoses included diabetes, peripheral vascular disease (PVD, a narrowing of blood vessels in 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
	265736	A. Building B. Wing	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	legs causing decreased circulation); -An order, dated, 3/12/26, wet to dry dressing, clean with wound cleaner, apply Medihoney (an ointment that removes dead tissue) to two wounds on the left foot on right side and on the top middle and a apply a border dressing (a specialized dressing); -No order for EBP. Review of the resident's care plan, in use at the time of survey, showed it did not address the resident's wounds or EBP. Observation on 3/23/26 at 6:40 A.M., showed Licensed Practical Nurse (LPN) P gathered supplies off of the treatment cart and entered the resident's room. The resident did not have an EBP sign posted on the door. A PPE supply drawer was not outside the resident's door. The resident was sitting in his/her wheelchair. The LPN removed the resident's left foot dressing dated 3/22/26, with gloved hands. The resident had two small wounds to his/her left foot. LPN P cleansed the resident's foot wounds with wound cleaner and applied Medihoney to the wound beds with gloved hands. LPN P then applied the border gauze that covered both of the resident's wounds. LPN P did not wear an isolation gown during the resident's dressing change. 3. 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 Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/19/25, showed: -admission date of 7/9/24; -Moderately impaired cognition; -Fully dependent on staff assistance for activities of daily living (ADLs); -Skin conditions, no concerns noted. Review for the resident's care plan, in use during the survey, showed no EBP concerns and no goals or interventions in place to prevent the resident from foreign pathogens. The resident had a right ankle wound and g-tube. Observation on 3/24/26 at 8:04 A.M., showed Certified Nursing Assistant (CNA) T and CNA U entered the resident's room. CNA T and CNA U washed hands and did not put on a gown. There was a PPE caddy outside the door, along with an EBP sign above the bed. The CNAs performed peri care (wash the genital area) and dressed the resident. During an interview on 3/25/26 at 8:37 A.M., CNA U said they did not use PPE (gown). The resident is on EBP for wounds and the g-tube. (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	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/27/26 at 12:20 P.M., the Director of Nursing (DON) said he expected staff to follow policies and procedures of the facility. Residents who are expected to be on EBP included residents with the following: Wound(s), G-tubes, and catheters. He expected staff to use a gown and gloves during invasive tasks or when providing direct care to the resident. There were no orders required for EBP; it is the nurses' best judgment. 4. Review of the facility's Equipment, Supplies, and Cleaning Policy, revised 2/3/21, showed: -If equipment must be used for more than one resident, it will be cleaned and disinfected before use on another resident, according to manufacturer's recommendations using Environmental Protection Agency (EPA)-registered disinfectants; -The facility will ensure healthcare personnel have access to EPA-registered hospital-grade disinfectants to allow for frequent cleaning of high-touch surfaces and shared resident care equipment. Observation on 3/23/26 between 8:47 A.M. and 9:08 A.M of the main dining room, showed LPN I provided blood sugar checks to residents in the dining room. At 8:53 A.M., LPN I used the glucometer to assess a resident's blood sugar level, providing the resident with a small cotton swab and returned to the treatment cart with the glucometer. LPN I did not disinfect the glucometer after removing his/her gloves and performing hand hygiene with alcohol-based hand sanitizer. At 8:57 A.M., LPN I used the glucometer to assess a second resident's blood sugar level, providing the resident with a small cotton swab and returning to the cart with the glucometer. No disinfectant was used on the glucometer after LPN removed his/her gloves and performed hand hygiene. At 9:03 A.M., LPN I used the glucometer to assess a third resident's blood sugar level, providing the resident with a small cotton swab and returning to the cart with the glucometer. No disinfectant was used on the glucometer before it was placed back into the treatment cart by LPN I. During an interview on 3/27/26 at 8:09 A.M., LPN C said glucometers should be cleaned after each resident's blood sugar is assessed. Glucometers are not to be used for multiple residents and should be sanitized with medical equipment disinfectant wipes, preferably those equipped to kill the hepatitis (bloodborne pathogen) virus. This is important to reduce the spread of infection between diabetic residents receiving insulin therapy and blood glucose level assessments at the facility. During an interview on 3/27/26 at 12:11 P.M. the facility Administrator, Director of Nursing, and Assistant Director of Nursing (ADON) said staff are instructed to clean the glucometer between residents with a medical equipment disinfectant wipe sufficient for the equipment's manufacturer's guidelines for cleaning. This is important to reduce the spread of blood-borne infections between residents. 5. Review of the facility's Infection Prevention and Control Program Policies and Procedures, dated August/2018, showed: -Due to recent shortage of serum for screening and testing for tuberculosis for new employees and newly admitted resident(s), CDC has issued the following direction; -The facility will: (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	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--Make every effort to obtain the tuberculin skin testing (TST, detects TB infection) supplies including checking with your local health department, all suppliers, etc in a timely manner; --Document all attempts to obtain the TST testing supplies and estimated times of delivery; -Until you can obtain the necessary TST testing supplies: --During the shortage, if supplies are still available, new employees should be administered the one-step TST upon hire, and then defer the second TST until the shortage resolves. If supplies are not available, conduct a symptom screen and document, --All new Admits will be assessed for signs and symptoms of TB upon admission to the building and this assessment documented; -- If the assessment of any employee or resident results in signs and symptoms of possible TB instruct them to see their physician or their local public health department; --Once TST testing supplies become available, all employees or resident(s) who required testing and were not tested, must be tested. The testing tis o be completed within a reasonable time period, usually within 30 days of obtaining the supplies; Tuberculosis Control: General Statement: -Resident and staff TB screening program will be implemented based upon the annual TB risk assessment in accordance with applicable state and local regulations. Review of the resident's #49's medical record, showed: -admission date of 1/6/26; -Moderately impaired cognition; -Independent with ADLs. Review of the resident's Immunizations Consent sheet dated 1/6/26, showed the resident consented to receive the 2-step TB test, however the facility could not provide any documentation related to if the resident did in fact receive the test. During an interview on 3/26/26 at 9:16 AM, the ADON said there is no documentation regarding the 2-step test aside from the consent form. The ADON would need to talk to the admitting nurse and see if he/she remembered. At this point, they would have to say the resident did not receive the TB test. During an interview on 3/27/2026 at 12:20 P.M., the DON said he expected the nurse to follow the facility's policy and protocol related to TB testing. The shift nurse was responsible for administering a TB test to newly admitted residents. The medical doctor would need to be aware if/when a TB test could not be administered within the recommended timeframes of the policy. (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	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/27/2026 at 12:20 P.M., the Regional Nurse said she was unaware of what the policy stated regarding the TB testing.

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	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 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. Based on observation, interview and record review, the facility staff failed to treat residents with dignity while providing care to one resident (Resident #5). The sample size was 20. The census was 81. Review of the facility's Resident Rights policy, last revised 8/31/26, showed: The resident has a right to a dignified existence. The facility must treat each resident with respect and dignity. Review of Resident #5's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/9/26, showed cognitive status not assessed. Review of the resident's medical record, showed diagnoses included Alzheimer's disease, dementia, and gastrostomy tube (G-Tube), a tube that is surgically inserted into the abdomen and is used for medications and liquid nutrition. Observation on 3/25/26 at 8:53 A.M., showed Registered Nurse (RN) Q prepared the resident's medication at the medication cart and entered the resident's room without knocking. The resident lay in bed. RN Q moved the resident's arms away to obtain access to the resident's hygiene g-tube. RN Q did not explain to the resident what care he/she was going to be providing before touching the resident. RN Q did not pull the privacy curtain between the resident and the resident' roommate. RN Q did not close the resident's door. RN Q administered the resident his/her medication through his/her g-tube. The resident's roommate watched RN Q give the resident his/her medication. Multiple staff members walked past the resident's room and residents in wheelchairs propelled past the resident's room and could see directly into the resident's room while RN Q was providing resident care. During an interview on 3/25/26 at 9:16 A.M., RN Q said he/she should have knocked before entering and immediately explained to the resident what he/she was doing. The resident's privacy curtain should have been pulled so the resident's roommate could not directly watch the care RN Q provided. If the curtain wasn't pulled, the resident's door should have been closed while care was being provided. During an interview on 3/27/26 at 8:39 A.M. Certified Nursing Assistant (CNA) C said staff should knock on the door before entering and wait for an answer. Staff should also explain the care they would be providing to the resident, pull the privacy curtain, and close the residents' door before providing care. All residents were to be treated in a respectful and dignified manner. During an interview on 3/27/26 at 12:22 P.M., the Administrator said she would expect all residents to be treated with dignity and respect. The staff were expected to knock before entering the resident's room, explain all care that was going to be provided and pull the privacy curtain before care was provided. If the privacy curtain was not pulled the resident's door was expected to be closed.

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	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 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. (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	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	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.

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	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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure advance directive/code status forms (a legal document, often a Do Not Resuscitate (DNR) order, that tells medical professionals not to perform cardiopulmonary resuscitation (CPR) if the heart or breathing stops) were not documented, updated and/or reviewed annually for three of 20 sampled residents (Residents #7, #15, and #47). The census was 81.Review of the facility's Advance Directive policy, dated [DATE], showed:-Policy statement: Advance directives will be respected in accordance with state law and facility policy;-Policy Interpretation and Implementation;-Upon admission, the resident will be provided with the written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so;-Written information will include a description of the facility's policies to implement advance directives and applicable state law;-Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record;-The Attending Physician will provide information to the resident and legal representative regarding the resident's health status, treatment options and expected outcomes during the development of the initial comprehensive assessment and care plan;-The plan of care for each resident will be consistent with his or her documentation treatment preference and/or advance directive;-The interdisciplinary Team will review annually with the resident his/her advance directives to ensure that such directives are still the wishes of the resident. Such reviews will be made during the annual Minimum Data Set ((MDS) a federally mandated assessment instrument completed by facility staff) assessment process. 1. Review of Resident's #7's annual MDS, dated [DATE], showed:-Moderately impaired cognition;-Diagnoses included Alzheimer's Disease (impaired memory), hospice care and protein calorie malnutrition (a critical deficiency in protein intake-often coupled with inadequate caloric consumption). Review of the resident's physician's order summary (POS), dated [DATE], showed an order, dated [DATE], for a full code (perform all life saving measures). Review of the resident's hospice binder, showed an order, dated [DATE], for outside the hospital, Do Not Resuscitate (OHDNR). Review of the resident's electronic medical record (EMR), reviewed [DATE] at 9:40 A.M., showed the banner at the top of the resident's home page as DNR. Review of the resident's care plan, in use during the time of the survey, reviewed [DATE] at 9:40 A.M., showed code status was not addressed. During an interview on [DATE] at 8:23 A.M., Licensed Practical Nurse (LPN) L said the full code order should have been changed and/or canceled to reflect the resident's code status in the hospice binder. He/she said code status should have been entered onto the face sheet. LPN L said if he/she could not locate the code status, he/she would start CPR and call 911. 2. Review of Resident #15's admission MDS, dated [DATE], showed:-Moderately impaired cognition;-Diagnoses included Huntington's disease (neurodegenerative disorder causing progressive breakdown of brain nerve cells) and weakness. Review of the resident's physician's order summary (POS), dated 3/2026, reviewed [DATE] at 7:42 A.M., showed the resident did not have an active order for an advanced directive. Review of the resident's electronic medical record (EMR), reviewed [DATE] at 7:00 A.M., showed:-The resident did not have a baseline care plan;-The banner at the top of the resident's home page did not indicate the resident's advanced directive;-In the document section, a full code advanced directive, signed by both the resident and physician on [DATE], was located. Observation and interview on [DATE] at 9:48 A.M., showed Certified Nursing Assistant(CNA) D pulled up the resident's page on the tablet where he/she charted. The main screen did not indicate the resident's advanced directive. He/She said if the code status was not on the main page, he/she would go to the resident's care plan. He/She clicked on resident care plan and a box popped up indicating that the resident did not have a care plan. He/She said he/she would also look at the care plan binder at the nurse's station but was unable to locate it. (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	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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	He/She said the resident's advanced directive should be readily available to all staff to ensure the resident's wishes were followed. During an interview on [DATE] at 6:29 A.M., LPN A said the advanced directive should have been added to the resident's EMR once the signed document was received. The advanced directive should be readily available to all staff so the resident's wishes were followed. 3. Review of Resident #47's quarterly MDS, dated [DATE], showed:-Diagnoses included chronic respiratory failure, dementia, major depressive disorder, chronic kidney disease, and schizoaffective disorder (mental health condition that includes features of both schizophrenia and a mood disorder);-Severe cognitive impairment. Review of the resident's care plan, in use at the time of the survey, showed:-Focus: Advanced directive, full code status. Review of the resident's EMR, reviewed on [DATE] at 10:07 A.M., showed:-The banner at the top of the resident's home page indicated the resident's advanced directive as full code;-In the documents section, an advanced directive, signed by the resident on [DATE], indicated a full code advanced directive. Review of the resident's hospice binder, reviewed on [DATE] at 10:35 A.M., showed a do not resuscitate advanced directive, signed by the resident and the physician on [DATE]. During an interview on [DATE] at 6:29 A.M., LPN A said the advanced directive in the resident's EMR should match the advanced directive in the resident's hospice binder. He/She said the old advanced directive should have been removed from the resident's EMR and the updated directive should have been entered. During an interview on [DATE] at 12:20 P.M., the Director of Nursing (DON) said he would have expected the resident(s) code status' to be constant throughout the chart. He said all residents should have a care plan that focuses and had inventions related to code status.

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	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 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 inflict 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)

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	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 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)

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	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 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

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	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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident's Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff) accurately reflected the resident's status of having a life expectancy of less than six months when they received hospice services (a service provided when a resident has a condition indicating a life expectancy of less than six months as certified by the hospice physician) for two of eight residents identified by the facility as receiving hospice services (Residents #47 and #69). The census was 81. 1. Review of Resident #47's quarterly MDS, dated [DATE], showed:-Diagnoses included chronic respiratory failure, dementia, major depressive disorder, chronic kidney disease, and schizoaffective disorder (mental health condition that includes features of both schizophrenia and a mood disorder);-Severe cognitive impairment;-Section J (health conditions) was marked as no for having a life expectancy of six months or less. Review of the 60-day physician recertification of terminal illness, dated 2/6/26, reviewed on 3/26/26 at 12:30 P.M., showed:-Certification statement: I certify that this patient is terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course. 2. Review of Resident #69's comprehensive MDS, dated [DATE], showed:-Diagnoses included dementia, chronic kidney disease, type two diabetes, and muscle weakness;-Severe cognitive impairment;-Section J was marked as no for having a life expectancy of six months or less;-Section O (special procedures) was marked as yes for hospice. Review of the resident's hospice order, dated 2/12/26, reviewed on 3/26/26 at 12:30 P.M., showed:-Order description: the medical director/hospice physician listed above certifies that the patient's prognosis is six months or less if the disease runs its normal course. During an interview on 3/27/26 at 12:45 P.M., the Administrator and Regional Director of Clinical Services said they would expect the MDS assessments to be accurate. They would expect the MDS section J to indicate that both residents had a life expectancy of six months or less.

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	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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on observation, interview, and record review, the facility failed to ensure one of 20 sampled residents had a baseline care plan created within 48 hours of admission (Resident #15). The census was 81. Review of the facility's Baseline Care Plan policy, dated 8/2017, showed:-Policy: The facility will develop and implement a baseline plan of care for each resident that includes the instructions needed to provide effective person-centered care of the resident that meet professional standards of quality care. The baseline care plan will include the minimum healthcare information necessary to properly care for each resident immediately upon their admission, which would address resident-specific health and safety concerns to prevent decline or injury, such as elopement or fall risk, and will identify needs for supervision, behavioral interventions, and assistance with activities of daily living, as necessary;-Procedure: The baseline plan of care will be developed within 48 hours of resident's admission and will include the minimum healthcare information necessary to properly care for the resident including, but not limited to: initial goals based on admission orders, physician orders, dietary orders, therapy services, and social services. 1. Review of Resident #15's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/19/26, showed:-Diagnoses included Huntington's disease (neurodegenerative disorder that causes progressive brain cell decay) and weakness;-Moderately impaired cognition. Review on 3/24/26, of the resident's electronic medical record (EMR), showed:-The resident did not have a baseline care plan. Observation and interview on 3/26/26 at 9:48 A.M., showed Certified Nursing Assistant (CNA) D pulled up the resident's page on the tablet where he/she charted. He/She clicked on resident care plan and a box popped up indicating the resident did not have a care plan. He/She said the resident should have a care plan so staff would know how to care for him/her. During an interview on 3/27/26 at 7:28 A.M., Licensed Practical Nurse (LPN) C reviewed the resident's EMR and confirmed the resident did not have a care plan. He/She would expect the resident to have a baseline care plan completed within 48 hours of admission to ensure staff knew how to care for the resident. During an interview on 3/27/26 at 12:39 P.M., the Administrator and Director of Nursing (DON) said they would expect for the resident to have had a care plan created upon 48 hours of his/her admission. They would expect for the resident to have a care plan to ensure the resident was properly cared for.

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	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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure three of 20 sampled residents received comprehensive care plans specific to their needs while admitted at the facility (Residents #26, #47 and #77). Resident #26's care plan did not include information and interventions for multiple falls in the facility, Resident #47's care plan did not include hospice services, and Resident #77's care plan did not include concerns regarding skin conditions. The census was 81.Review of the facility's Resident Assessment Instrument (RAI) policy, revised, 10/20/22, showed:-Within seven days of the completion of the resident assessment, a comprehensive care plan will be developed. Care plans shall be culturally competent and trauma-informed. This includes interventions that reflect the resident's cultural preferences, values, and practices and accounting for resident's experiences and preferences in order to eliminate or mitigate triggers that cause re-traumatization;-The Interdisciplinary Team must develop, review, and update the care plan when there has been a significant change in the resident's condition, when the desired outcome is not met, when the resident is readmitted from the hospital, or at least quarterly in conjunction with the required quarterly assessments. 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 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 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;-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. 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;-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 list any fall interventions put in place. During an interview on 3/27/26 at 7:24 A.M., Certified Nursing Assistant (CNA) B said the resident's care plan should include the resident's falls and fall interventions that have been put in place. This is important because the care plan is how CNAs know how to care for the resident. During an interview on 3/27/26 at 7:28 A.M., Licensed Practical Nurse (LPN) C said the resident's care plan needed to be updated. He/She expected the resident's care plan to indicate the resident's fall risk and interventions used to prevent falls. The Director of Nursing was responsible for updating the care plans. During an interview on 3/27/26 at 12:39 P.M., the Administrator and Director of Nursing (DON) said they expected the care plan to be updated to include the resident's falls and interventions that have been put in place to prevent future falls. 2. Review of Resident #47's quarterly MDS, dated [DATE], showed:-Diagnoses included chronic respiratory failure, dementia, major depressive disorder, chronic kidney disease, and schizoaffective disorder (mental health condition that includes features of both schizophrenia and a mood disorder);-Severe cognitive impairment. Review on 3/23/26, of the resident's electronic medical record (EMR), showed the resident started receiving hospice services on 10/8/25. Review of the resident's care plan, in use at the time of the survey, showed no indication of the resident being placed on hospice or interventions related to hospice care. (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	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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/27/26 at 7:28 A.M., LPN C said he/she expected the resident's care plan to indicate that the resident is receiving hospice services. During an interview on 3/27/26 at 12:39 P.M., the Administrator and DON said they expected the care plan to be updated to reflect that the resident is receiving hospice services. 3. 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 activities of daily living (ADLs);-No skin concerns noted. Review of the Braden Scale report predicting pressure sores, 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 physician's orders sheet (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. 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. Review of the of Wound Specialist's progress note, dated 3/25/26, showed:-Onset wound date 3/25/26, stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough. May also present as an intact or open/ruptured blister) pressure injury over right ankle, measurements are 0.5 centimeters (cm) by 1.5 cm by 0.1 cm, moderate serous (clear or slightly yellow drainage drainage), no signs or symptoms of infection;-Treatment order: Cleanse wound with normal saline or sterile water, apply alginate (absorbent wound dressing) to wound bed, cover with dry clean dressing. 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. During an interview on 3/27/26 at 12:20 P.M., the DON said he expected nursing staff to follow facility policies. All care plans should be updated by the MDS coordinator within 24-48 hours to reflect new changes for the resident. 4. During an interview on 3/27/26 at 8:26 A.M., CNA H said care plans are important because they help facility nursing staff provide care personalized to each resident. 5. During an interview on 3/27/26 at 8:09 A.M., LPN C said each resident should have a care plan completed upon admission personalized to each resident's specific care needs. Care plans should include personal preferences, psychosocial care needs, interest in activities, and other resident care needs. 6. During an interview on 3/27/26 at 12:21 P.M., the facility Administrator, DON, and Assistant Director of Nursing (ADON) said all residents should have a comprehensive care plan completed within 14 days after admission to the facility. Care plans are important as they provide nursing staff personalized care information specific to each resident's needs.

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	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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview and record review, the facility failed to ensure one resident (Resident #46) received care and services in accordance with professional standards by failing to notify the physician the resident was not wearing thromboembolic deterrent stockings (TEDS) (stockings used to prevent blood clots in the legs). The facility also failed to provide alternative interventions to address the resident's lower leg edema (swelling). The sample size was 20. The census was 81. Review of the facility's Obtaining and Following Physician orders, last revised, July 2017, showed:-Policy: Physician orders will be obtained by licensed personal and followed; If the licensed professional does not in his/her best judgement think that the order is not in the best interest of the resident, he/she has the obligation to further investigate prior to fulfilling the order; If these orders are not followed by any reason, the physician and Director of Nursing (DON) will be promptly notified. Review of Resident #46's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated, 3/9/26, showed:-Moderate cognitive impairment;-Diagnoses include heart failure and diabetes;-Requires set up from staff for putting on and taking off footwear. Review of the resident's medical record, showed diagnoses included mild intellectual disabilities and borderline intellectual functioning. Review of the resident's care plan, in use at the time of survey, showed:-Focus: The resident is at risk for dehydration related to diuretic (a medication used to remove excess fluid) for heart failure;-Interventions: TEDS, as ordered. Review of the resident's medication administration record (MAR), dated 2/1 through 2/28/26, showed:-An order, dated 8/8/26, TEDS, apply in A.M. and remove in P.M.;-Documented as not administered on 17 out of 28 opportunities: 7:00 A.M. through 7:00 P.M.;-On 2/23/26 and 2/26/26, 7:00 A.M. through 7:00 P.M. shift documented the reason the TEDS were not administered showed: The resident said the TEDS were too tight. Review of the resident's MAR, dated 3/1 through 3/26/26, showed:-An order, dated 8/8/26, TEDS, apply in A.M. and remove in P.M.;-Documented as not administered for 14 out of 26 opportunities 7:00 A.M. through 7:00 P.M.;-On 3/9/26, 7:00 A.M. through 7:00 P.M. shift documented the reason the TEDS were not administered showed: The resident does not wear TEDS;-On 3/23/26, 7:00 A.M. through 7:00 P.M. shift the documented the reason the TEDS were not administered showed: The resident said the TEDS were too tight. Review of the resident's focused observation assessment, dated 3/23/26 at 11:32 P.M., showed:-Edema present: Blank;-Left leg edema: Blank;-Right leg edema: Blank. During an observation and interview on 3/23/26 at approximately 11:30 A.M., the resident said his/her legs hurt. The resident's lower legs had a moderate amount of edema. The resident said his/her legs felt swollen and heavy and it caused him/her to have discomfort. The resident said he/she was supposed to wear TEDS, but they were too tight. The resident was not wearing TEDS. The resident said staff have not offered an alternative to the stockings to help with his/her edema. Observation and interview on 3/24/26 at approximately 5:00 P.M., showed the resident lay in bed. The resident was crying and said his/her legs were hurting bad. The resident's legs were moderately edematous (swelling with fluid). The resident's left leg was more edematous than the right leg. The resident continued to cry and rubbed his/her legs saying his/her legs were so swollen and hurt. The DON entered the resident's room and assessed the resident. The resident was not wearing TEDS. Review of the resident's progress notes dated 2/26 through 3/24/26, showed:-On 3/24/26 at 5:40 P.M., The DON assessed the resident, bilateral (both) lower extremities were warm to touch. Pedal (foot) pules were withing normal limits. The resident said he/she was having pain to bilateral lower legs and winces in pain when touched. The resident said his/her pain level was 5 out of 10. The physician was called. The resident refused to go to the hospital. Venous doppler (test to check for blood clots in the legs) ordered;-No documentation that the resident's physician was notified that the resident was not wearing TEDS;-No documentation that further recommendations were received for the resident's bilateral leg edema. Observation and interview on 3/25/26 at 8:16 A.M., showed the resident walked into the dining room for breakfast. The resident had moderate (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	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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	edema to both legs. The resident was not wearing TEDS. Certified Medicine Technician (CMT) R said the resident's legs were always swollen. During an observation and interview on 3/27/26 at 8:25 A.M., the resident said his/her legs continued to feel heavy, tight, and uncomfortable. The resident's bilateral legs showed moderate edema. The resident was not wearing TEDS. The resident said he/she was willing to try an alternative to TEDS but the TEDS the staff tried to place on him/she was too tight. During an interview on 3/26/26 at 2:32 P.M., Licensed Practical Nurse (LPN) I said he/she did not know any interventions off the top of his/her head that could help the resident with his/her edema. During an interview on 3/27/26 at 8:39 A.M. Certified Nursing Assistant (CNA) B said the resident's legs were usually swollen and had not seen the resident wear anything on his/her legs to help with the swelling. During an interview on 3/27/26 at 10:28 A.M., LPN C said the resident had not been wearing TEDS. LPN C said the physician should be called and notified the resident had not been wearing TEDS. Alternatives to the resident's edema could be a leg sleeves, elevating his/her legs when sitting, or a bigger size in the TEDS. During an interview on 3/27/26 at 12:22 P.M. the DON said he would expect the physician to be notified the resident was not wearing the TEDS as ordered after a couple of missed times. The Nurse Practitioner (NP) was always in the building and staff should have notified the NP about the resident's leg edema and discomfort. He would have expected staff to obtain alternative orders and interventions to the TEDS.

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	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 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)

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	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 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)

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	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 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)

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	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 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)

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	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 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

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	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 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)

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	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 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

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	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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review, the facility failed to ensure physician's orders for catheter (a thin flexible tube inserted into the body to drain fluids (usually urine) or inject fluids/medication) care was obtained for one of one resident sampled with a catheter (Resident #2). The census was 81. Review of the facility's Catheter Care policy, dated 7/2017, showed:-Purpose: the purpose of this procedure is to prevent catheter-associated urinary tract infections;-Maintain an accurate record of the resident's daily output, per facility policy and procedure;-Observe the resident for complications associated with urinary catheters. 1. Review of Resident #2's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/26/26, showed:-Diagnoses included end stage renal disease, legal blindness, dementia, and major depressive disorder;-Moderately impaired cognition. Review of the resident's care plan, in use at the time of the survey, showed:-Problem: the resident has a suprapubic (a hollow tube inserted into the bladder through a small temporary abdominal incision to drain urine when the urethra cannot be used) catheter;-Goal: will be monitored and treated for: obstruction, signs of infection, dislodgment ofcatheter, bowel perforation, or trauma secondary to catheter manipulation throughnext review date;-Approaches: document urinary output every shift and as needed. Record the amount, type, color, and odor. Review on 3/24/26 at 9:51 A.M., of the resident's physician orders summary (POS), dated 3/2026, showed no physician orders for catheter care, catheter maintenance, or catheter observation. Observation on 3/24/26 at12:02 P.M., showed the resident sat on the side of his/her bed awake. The resident pulled up his/her pant leg to expose his/her catheter. The bag and tubing were undated. During an interview on 3/27/26 at 7:28 A.M., Licensed Practical Nurse (LPN) C said the resident should have physician's orders for catheter care. He/She said normally there were orders for monitoring for side affects and for tubing change frequency. During an interview on 3/27/26 at 12:42 P.M., the Administrator and Director of Nursing (DON) said there should be physician orders for catheter care. They would expect the order to include monitoring for catheter concerns and monitoring for urine input and output.

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	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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, and record review, the facility failed to ensure staff maintained the head of the bed in an elevated position during gastrostomy tube (g-tube, a tube surgically inserted into the abdomen used for liquid nutrition, fluids, and medications) feeding for one resident (Resident #5). This deficient practice had the potential to place the resident at risk for complications, including aspiration (choking). The sample was 20. The census was 81. Review of the facility's Tube Feeding, Bolus (large amount given at one time) policy, revised 3/28/25, showed:-Policy: It is the policy that residents' nutritional needs will be met by a tube feeding, when oral consumption is not possible and the resident consents;-Maintain the head of the resident's bed at a minimum of 30 degrees. Review of the facility's Tube Feeding, Open System policy, dated 3/28/25, showed the policy did not address the position of the head of the bed while tube feeding is infusing. Review of Resident #5's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/19/26, showed:-Dependent on staff for assistance with eating;-Diagnoses included Alzheimer's disease, dementia, and malnutrition;-Use of feeding tube. Review of the resident's care plan, in use at the time of survey, showed: -Focus: The resident is at risk for dehydration, secondary to tube feeding;-Intervention: Keep head of bed elevated while in bed. Review of the resident's physician order sheets (POS), dated March 2026, showed;-An order, dated 10/17/25, for Jevity 1.5 cal (a type of liquid nutrition) at 45 milliliters (ml) per hour and water flush 150 ml every four hours through g-tube;-An order, dated 10/17/25, to elevate the head of bed 30 degrees while receiving continuous tube feeding. Observations on 3/23/26 at 11:45 A.M. and 12:00 P.M., on 3/24/26 at 12:01 P.M., and on 3/25/26 at 8:55 A.M., showed the resident lay in bed with tube feeding pump on and connected to the resident. The head of the resident's bed positioned at approximately 10 degrees. Observations on 3/26/26 at 6:30 A.M., 8:55 A.M., and 10:58 A.M., showed the resident lay in bed with tube feeding pump on and connected to the resident and the head of the resident's bed flat. During an interview on 3/27/26 at 8:39 A.M., Certified Nursing Assistant (CNA) B said the resident's head of bed should be elevated 30 to 45 degrees while receiving tube feeding to prevent aspiration. During an interview on 3/27/26 at 10:28 A.M., Licensed Practical Nurse (LPN) C said the resident's head of bed should be positioned 45 to 90 degrees while receiving tube feeding to prevent aspiration. During an interview on 3/27/26 at 12:22 P.M., the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) said the resident's head of bed is expected to be at 45 degrees while receiving tube feeding to prevent aspiration.

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	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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on observation and record review the facility failed to provide or obtain laboratory services to meet the needs of one resident (Resident #53). The sample was 20. The census was 81.Review of the facility's Laboratory Reports policy, last revised, July 2014, showed:-Policy: All lab reports will be reviewed by a nurse and reported to the physician as necessary;-Procedure: The night nurse will follow-up nightly through chart audit to ensure all labs have been performed as ordered, physician has been notified of results and reports are filed in the resident's record; If the nurse determines that a lab report has not been received, the nurse will obtain the lab results and notify the physician. Review of the facility's Obtaining and Following Physician orders, last revised, July 2017, showed:-Policy: Physician orders will be obtained by licensed personal and followed; If these orders are not followed by any reason, the physician and Director of Nursing (DON) will be promptly notified;-Procedure: If there is a new order, write the new order on the physician order sheet or entered into the electronic health record (EHR). Review of Resident #53's, quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/9/26, showed diagnoses include seizure disorder, anxiety and traumatic brain dysfunction. Review of the resident's progress notes on 2/13/26 at 11:46 A.M., showed at 8:00 A.M., the nurse assistant came to the nurses' station and said the resident was slumped over to the right side and unresponsive while out on a smoke break. The resident was sitting up and conscious and the resident was provided a wheelchair and escorted back into the building, The resident did not have facial drooping, weakness of the arms and legs. Both hand grips were equal in strength. The resident was slightly confused and could only answer yes and no questions. The resident was showing signs and symptoms of seizure activity, by decrease responsiveness. No complaints of pain or injury. The resident then stood up and walked to breakfast. Seizure precautions in place and will be monitored. The physician was notified and ordered a complete blood count (CBC), a blood test that measures cell circulating in the body, comprehensive metabolic panel (CMP), a blood test that checks electrolytes and organ function in the body, and a Keppra (a medication used to treat seizures) level. Review of the resident's physician order sheets (POS), dated February and March 2026, showed no physician orders for a CBC, CMP, or Keppra level. During an interview on 3/36/26 at 2:50 P.M., Licensed Practical Nurse (LPN) L said he/she did not see any physician orders for lab work for the resident. LPN L said once the lab orders were obtained by the physician, then an order should be placed in the resident's physician orders. The nurse is then to enter the lab request in the lab portal. The lab came all days of the week. During an interview on 3/27/26 at 8:39 A.M., the DON and the Administrator said the resident's labs were not done. The nurse that entered the progress notes about the labs was new and did not inform nursing management of any concerns about obtaining labs. During an interview on 3/27/26 at 12:22 P.M., the DON said he would expect the staff to place physician orders in the resident's medical record. Lab requests were expected to be entered into the lab portal. If the nurse didn't know how and could not log into the lab portal, he would have expected the staff to notify him.

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	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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on observation, interview, and record review, the facility failed to provide routine dental care to meet the needs of one resident (Resident #10). The sample was 20. The census was 81.Review of facility's Dental Examination and Assessment policy, last revised, July 2014, showed:-Policy: Each resident shall undergo a dental assessment by facility nurses as part of the Nursing assessment process upon admission;-Policy interpretation: Prior to, or within 90 days after admission, the resident shall undergo a dental examination; Dental examinations will be made b the resident's personal dental dentist or by the facility's consulting dentist; Records of dental care provided shall be made a part of the resident's medical record; Upon conducting a dental examination, a resident needing dental services will be promptly referred to a dentist. Review of Resident #10's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/9/26, showed:-Moderate cognitive impairment;-Requires set up and clean up assistance from staff for oral hygiene. Review of the resident's care plan, in use at the time of survey, showed:-Focus: The resident requires assistance with activities of daily living related to poor follow through and decreased task initiation;-Approach: The resident requires set up, supervision, and verbal cures for oral care. Review of the medical record, showed the resident's diagnoses included: Nicotine dependence to cigarettes, anxiety, bipolar disease (a mental disorder that causes extreme mood swings), and adult failure to thrive. Review of the resident's physician order sheets, dated March 2026, showed no order for the resident to see the dentist. Review of the resident's observation detail list report focused observation, dated 3/10/26, showed:-Oral cavity assessment: Blank. Review of the facility's dentist consult list, showed the resident not listed for the 1/7/26 and 2/25/26 dental visits. Observation and interview on 3/25/26 at approximately 9:30 A.M., showed the resident began speaking and was noted to have halitosis (bad breath). The resident said he/she had not seen a dentist in a very long time. When the resident smiled, the resident had multiple teeth that were dark brown and black. Some of the resident's teeth were chipped and missing. The resident said he/she would try to see a dentist if he/she could. The resident said he/she did not know where his/her toothbrush was, and he/she has smoked cigarettes for over 30 years. During an interview on 3/27/26 at 8:39 A.M., Certified Nursing Assistant (CNA) B said he/she has provided care to the resident. CNA B did not notice the resident had issues with his/her teeth or had halitosis. The resident required reminders about personal hygiene. During an interview on 3/27/26 at 12:22 P.M., the Director of Nursing (DON) and Assistant Director of Nursing (ADON) said they would expect all residents to have their oral cavity inspected routinely and as needed. If a resident is in need of dental care, the nurse is expected to let the Social Services Director know that the resident needs to be placed on the dentist list.