Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23542A	A. BUILDING: _____ B. WING _____	C 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCKNIGHT PLACE ASSISTED LIVING AND MEMORY	THREE MCKNIGHT PLACE SAINT LOUIS, MO 63124

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A2010	19 CSR 30-85.022(6) Oxygen Storage Oxygen storage shall be in accordance with NFPA 99, 1999 edition. Facilities shall use permanent racks or fasteners to prevent accidental damage or dislocation of oxygen cylinders. Safety caps shall remain intact except where a cylinder is in actual use or where the regulator has been attached and the cylinder is ready for use. Individual oxygen cylinders in use or with an attached regulator shall be supported by cylinder collars or by stable cylinder carts. II/III This regulation is not met as evidenced by: Class II* Based on observation and interview, the facility failed to maintain oxygen cylinder storage according to NFPA code. This deficient practice had the potential to affect all occupants in one of three smoke compartments. The census was 24. 1. Observation on 8/1/24 at 7:45 A.M., of the oxygen closet, showed the following: -The closet measured approximately 3 feet by 10 feet; -Nine large, empty tanks and one full tank stored in a metal crate, on the floor; -Two plastic bins of oxygen tubing and supplies sat on a cart in the closet next to the oxygen tanks; -Several plastic biohazard bags, lay on the floor next to the cart. During an interview on 8/1/24 at 9:20 A.M., the Director of Maintenance said he knew full and empty tanks should not be stored together and combustibles should not be in the same closet as the oxygen. Central Supply put the full tanks in the closet and Nursing was responsible for placing the empty tanks in the closet.	A2010		

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A2010	Continued From page 1 During an interview on 8/1/24 at 2:45 P.M., the Administrator said full and empty oxygen tanks should not be stored together. Staff should not have been storing combustibles in the same closet as the oxygen. Nursing staff were responsible for maintaining the oxygen closet. NFPA 99 (2012) 11.3 Cylinder and Container Storage Requirements. 11.3.2.3 Oxidizing gases, such as oxygen and nitrous oxide, shall be separated from combustibles or materials by one of the following: (1) Minimum distance of 6.1 m (20 ft); (2) Minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems; (3) Enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. NFPA 99 (2012), 11.6.5 Special Precautions - Storage of Cylinders and Containers. 11.6.5.1 Storage shall be planned so that cylinders can be used in the order in which they are received from the supplier. 11.6.5.2 If empty and full cylinders are stored within the same enclosure, empty cylinders shall be segregated.	A2010		
A2016	19 CSR 30-85.022(8)(D) Fire Extinguisher UL/FM, Monthly Check Fire Extinguishers. (D) All fire extinguishers shall bear the label of the UL or the FM Laboratories and shall be	A2016		

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A2016	Continued From page 2 installed and maintained in accordance with NFPA 10, 1998 edition. This includes the documentation and dating of a monthly pressure check. II/III This regulation is not met as evidenced by: Class II* Based on observation and interview, the facility failed to maintain all fire extinguishers according to NFPA standards. This deficiency had the potential to affect all occupants in three of three smoke compartments. The census was 24. Observations during the fire safety tour on 8/1/24 between 7:00 A.M. and 2:00 P.M.,showed the following: -The ABC fire extinguisher, adjacent to room 19, mounted more than 60 inches above the finished floor; -The ABC fire extinguisher, adjacent to room 25, mounted more than 60 inches above the finished floor; -The ABC fire extinguisher, adjacent to room 10, mounted more than 60 inches above the finished floor; -The ABC fire extinguisher, adjacent to room 32, mounted more than 60 inches above the finished floor. During an interview on 8/1/24 at 9:15 A.M., the Maintenance Director said he did not know fire extinguishers were not supposed to be over five feet from the floor. It was concerning because the fire extinguishers had been mounted like that for over 20 years. During an interview on 8/1/24 at 2:45 P.M., the Administrator said she knew fire extinguishers could not be more than five feet from the floor but	A2016		

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A2016	Continued From page 3 did not know there were fire extinguishers that were mounted that high. NFPA 10 (2010) 6.1.3.8 Installation Height. 6.1.3.8.1 Fire extinguishers having a gross weight not exceeding 40 pounds shall be installed so that the top of the fire extinguisher is not more than 5 feet above the floor.	A2016		
A2025	19 CSR 30-85.022(10)(H) Fire Alarm System-Out of Service > than 4hrs Complete Fire Alarm Systems. (H) When a complete fire alarm system is to be out-of-service for more than four (4) hours in a twenty-four- (24-) hour period, the facility shall immediately notify the department and the local fire authority and implement an approved fire watch in accordance with NFPA 101, 2000 edition, until the fire alarm system has returned to full service. I/II This regulation is not met as evidenced by: Class II Based on observation, interview, and record review, the facility staff failed to ensure a complete policy was in place on the procedures to be followed in the event the fire alarm system was out of service for more than four hours in any 24 hour period. This failure had the potential to affect all facility occupants. The census was 24. 1. Observation on 8/1/24 during the fire safety tour, showed the facility equipped a complete fire alarm system. 2. Review of the facility's undated Fire Watch	A2025		

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A2025	Continued From page 4 Policy, showed the following: -Policy: The fire watch procedure is used when the fire suppression system (sprinkler system) or the smoke detection system is not in service due to an emergency, lack of water supply, or for repairs and maintenance; -The fire watch team will conduct a fire walk every 30 minutes throughout the affected area(s); -The fire watch emergency bag is located at the first floor nurse's station. Each team member making the 30 minute rounds will carry one of these bags. The bag's contents include: a small fire extinguisher, a clipboard with the fire watch log and a flash light; -Procedure: The charge nurse or manager on duty will contact the Director of Facilities and the Executive Director; -The charge nurse will assign maintenance, floor tech or Certified Nurse's Aide (CNA) to retrieve the fire watch emergency bag from the first floor nurse's station; -The charge nurse or manager on duty will contact the monitoring company, the fire department and insurance company to alert them the facility is currently on a fire watch; -When conducting the fire watch, each team member will patrol the affected area per the attached checklist by watching for any sign of an active fire. The team member will initial the log every 30 minutes; -If fire or smoke is detected during this fire watch procedure, the Code Red system will go into effect and 911 will be contacted immediately. The fire watch must still continue during this time; -Once the fire suppression system is returned to service, the charge nurse or manager on duty will contact the Executive Director, Director of Facilities, fire alarm company, fire department and insurance company; -After four hours if the system not restored:	A2025		

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A2025	Continued From page 5 Contact the Section for Long Term Care regional office; -When the system is returned to service, contact the Section for Long Term Care regional office; -No documentation of contact information for the fire alarm company or the insurance company; -No direction for staff to post a tag at each fire department connection, the system control valve, and other locations required by the authority having jurisdiction, indicating which system or part thereof, had been removed from service; -No direction regarding fire watch rounds, to include observing all exits and the exterior of the building; -No direction regarding documentation of fire watch rounds to include the rooms/areas checked; -No direction the staff conducting the fire watch should have no other duties; -No direction the staff conducting the fire watch should be trained in fire prevention and have a means to notify occupants of the building in the event of an emergency. 3. During an interview on 8/1/24 at 2:45 P.M., the Administrator said she knew the fire watch policy needed information about the staff being trained on fire prevention and having no other duties. She thought this information was in the fire watch policy. She did not know about the other missing information. NFPA 101 (2012): -3.3.104 Fire Watch. The assignment of a person or persons to an area for the express purpose of notifying the fire department, the building occupants, or both of an emergency; preventing a fire from occurring; extinguishing small fires; or protecting the public from fire or life safety dangers.	A2025		

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A2025	Continued From page 6 -Chapter 9, Building Service and Fire Protection Equipment -9.6, Fire Detection, Alarm, and Communications Systems -9.6.1.6* Where a required fire alarm system is out of service for more than four hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated, or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. -A.9.6.1.6 A fire watch should at least involve some special action beyond normal staffing, such as assigning an additional security guard(s) to walk the areas affected. Such individuals should be specially trained in fire prevention and in occupant and fire department notification techniques, and they should understand the particular fire safety situation for public education purposes. NFPA 101 (2012) 9.6.1.6* Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated, or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. NFPA 72 (2010) showed: Inspection, Testing and Maintenance -14.2.1.2.1 The requirements of Section 10.19 shall be applicable when a system is impaired. -14.2.1.2.2 System defects and malfunctions shall be corrected. -14.2.1.2.3 If a defect or malfunction is not corrected at the conclusion of system inspection, testing, or maintenance, the system owner or the	A2025		

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A2025	Continued From page 7 owner's designated representative shall be informed of the impairment in writing within 24 hours. -10.19* Impairments -10.19.3* Where required, mitigating measures acceptable to the authority having jurisdiction shall be implemented for the period that the system is impaired. -*A.10.19.3 The need for mitigating measures is typically determined on a case-by-case basis. This considers the building, occupancy type, nature and duration of impairment, building occupancy level during impairment period, active work being conducted on the fire alarm system during the impairment, condition of other fire protection systems and features (i.e., sprinklers, structural compartmentation, etc.), and hazards and assets at risk. Appropriate mitigating measures range from simple occupant notification to full-time fire watch. Determining factors vary from testing-related impairments and maintenance activities during normal business through extensive impairments to high-value, high-hazard situations. -*A.10.19 The term impairment encompasses a broad range of circumstances wherein a fire alarm system or portion thereof is taken out of service for a variety of reasons. Fire alarm systems are routinely impaired in order to perform hot work (e.g., open flame operations) in areas with automatic detection, construction, painting, etc., as well as to conduct normal fire alarm system maintenance and testing. Impairments can be limited to specific initiating devices and/or functions (e.g., disconnecting the supervising station connection during system testing), or they can involve taking entire systems or portions of systems out of service. This section is intended to help building owners control impairments of the fire alarm system(s) in their building(s) and to	A2025		

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A2025	Continued From page 8 ensure that systems are restored to full operation and/or returned to service afterward.	A2025		
A2034	19 CSR 30-85.022(11)(C) Sprinkler System-Test/Maintain Sprinkler System. (C) Facilities that have a sprinkler system installed prior to August 28, 2007, shall inspect, maintain, and test these systems in accordance with the requirements in effect for such facilities on August 27, 2007. I/II This regulation is not met as evidenced by: Class II Based on observation, interview and record review, the facility failed to maintain the sprinkler system in accordance with NFPA 25 (Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems). Staff failed to repair deficiencies documented in their annual sprinkler inspection in a timely manner. This deficient practice had the potential to affect all residents, staff and visitors in the event of an emergency. The facility census was 24. Review of the annual sprinkler inspection dated 3/26/24, showed: -Deficiency details: Question: Visible pipe fittings free from mechanical damage, leakage and external corrosion? No; -Tech notes: 2 inch riser in parking garage off zone 1 wet sprinkler system is corroded and should be replaced. Two inch main drain valves leaked from packing gland excessively during testing and packing gland could not be tightened; -Deficiency authority: NFPA 25 (2011) Section	A2034		

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A2034	Continued From page 9 5.2.2.1: Pipe fittings shall be in good condition and free of mechanical damage, leakage and corrosion; -Technician comments: Remove and replace 2 inch riser piece of pipe 0-8 thread by thread with a 2 x 1/2 x 1.5 tee in parking garage zone 1 wet sprinkler system. Remove and replace 2 inch main drain valves on zones 1 and 2 wet sprinkler systems. Remove and replace 4 inch wet system flow switch on zone 1 which looks to have been leaking internally. Company will contact you shortly to discuss how they can help you create an action plan to correct deficiencies identified in this inspection; -No documentation repairs were completed. During an interview on 8/1/24 at 12:55 P.M., the Maintenance Director said he thought the repairs had been completed and was going to contact the sprinkler company to get the documentation. During an interview on 8/1/24 at 2:45 P.M., the Administrator said maintenance staff were responsible for maintaining the sprinkler system. She would expect repairs to be made if noted in the sprinkler inspection. Review of an email sent by the facility on 8/1/24 at 3:17 P.M., showed: -The sprinkler company would be out on 8/2/24 to check the deficiencies on the report; -The sprinkler company usually corrected deficiencies right away, but if they missed any they would be repaired tomorrow or as soon as possible. Review of an email sent by the facility on 8/2/24 at 1:53 P.M., showed the sprinkler company repaired the deficiencies from the annual	A2034		

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A2034	Continued From page 10 sprinkler report.	A2034		
A2036	19 CSR 30-85.022(11)(E) Sprinkler System Out of Service More Than 4hr Sprinkler System. (E) When a sprinkler system is to be out-of-service for more than four (4) hours in a twenty-four- (24-) hour period, the facility shall immediately notify the department and the local fire authority and implement an approved fire watch in accordance with NFPA 101, 2000 edition, until the sprinkler system has returned to full service. I/II This regulation is not met as evidenced by: Class II Based on observation, interview and record review, the facility staff failed to ensure a complete policy is in place on the procedures to be followed in the event the sprinkler system is out of service for more than four hours in any 24 hour period. This failure had the potential to affect all facility occupants. The census was 24. 1. Observation on 8/1/24 during the fire safety tour, showed the facility equipped with an automatic sprinkler system. 2. Review of the facility's undated Fire Watch Policy, showed the following: -Policy: The fire watch procedure is used when the fire suppression system (sprinkler system) or the smoke detection system is not in service due to an emergency, lack of water supply, or for repairs and maintenance; -The fire watch team will conduct a fire walk every 30 minutes throughout the affected area(s);	A2036		

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A2036	Continued From page 11 -The fire watch emergency bag is located at the first floor nurse's station. Each team member making the 30 minute rounds will carry one of these bags. The bag's contents include: a small fire extinguisher, a clipboard with the fire watch log and a flash light; -Procedure: The charge nurse or manager on duty will contact the Director of Facilities and the Executive Director; -The charge nurse will assign maintenance, floor tech or Certified Nurse's Aide (CNA) to retrieve the fire watch emergency bag from the first floor nurse's station; -The charge nurse or manager on duty will contact the monitoring company, the fire department and insurance company to alert them the facility is currently on a fire watch; -When conducting the fire watch, each team member will patrol the affected area per the attached checklist by watching for any sign of an active fire. The team member will initial the log every 30 minutes; -If fire or smoke is detected during this fire watch procedure, the Code Red system will go into effect and 911 will be contacted immediately. The fire watch must still continue during this time; -Once the fire suppression system is returned to service, the charge nurse or manager on duty will contact the Executive Director, Director of Facilities, fire alarm company, fire department and insurance company; -After four hours if the system not restored: Contact the Section for Long Term Care regional office; -When the system is returned to service, contact the Section for Long Term Care regional office; -No documentation of contact information for the fire alarm company or the insurance company; -No direction for staff to post a tag at each fire department connection, the system control valve,	A2036		

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A2036	Continued From page 12	A2036		

and other locations required by the authority having jurisdiction, indicating which system or part thereof, had been removed from service;
-No direction the staff conducting the fire watch should have no other duties;
-No direction regarding fire watch rounds, to include observing all exits and the exterior of the building;
-No direction regarding documentation of fire watch rounds to include the rooms/areas checked;
-No direction the staff conducting the fire watch should be trained in fire prevention and have a means to notify occupants of the building in the event of an emergency.

3. During an interview on 8/1/24 at 2:45 P.M., the Administrator said she knew the fire watch policy needed information about staff being trained on fire prevention and having no other duties. She thought this information was in the fire watch policy. She did not know about the other missing information.

NFPA 25 (2011), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, under Chapter 15.5, Preplanned Impairment Programs, showed:
-15.5.1 All preplanned impairments shall be authorized by the impairment coordinator.
-15.5.2 Before authorization is given, the impairment coordinator shall be responsible for verifying that the following procedures have been implemented:
(1) The extent and expected duration of the impairment have been determined.
(2) The areas or buildings involved have been inspected and the increased risks determined.
(3) Recommendations have been submitted to management or the property owner or designated

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A2036	Continued From page 13 representative. (4) Where a required fire protection system is out of service for more than 10 hours in a 24-hour period, the impairment coordinator shall arrange for one of the following: (a) Evacuation of the building or portion of the building affected by the system out of service (b)*An approved fire watch (c)*Establishment of a temporary water supply (d)*Establishment and implementation of an approved program to eliminate potential ignition sources and limit the amount of fuel available to the fire (5) The fire department has been notified. (6) The insurance carrier, the alarm company, property owner or designated representative, and other authorities having jurisdiction have been notified. (7) The supervisors in the areas to be affected have been notified. (8) A tag impairment system has been implemented. (See Section 15.3.) (9) All necessary tools and materials have been assembled on the impairment site. And, at Annex A, Explanatory Material, showed: -A.15.5.2(4)(b) A fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. NFPA 101 (2012) -3.3.104, Fire Watch. The assignment of a person or persons to an area for the express purpose of notifying the fire department, the building	A2036		

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A2036	Continued From page 14 occupants, or both of an emergency; preventing a fire from occurring; extinguishing small fires; or protecting the public from fire or life safety dangers. NFPA 101 (2012) 9.6, Fire Detection, Alarm, and Communications Systems -A.9.6.1.6 A fire watch should at least involve some special action beyond normal staffing, such as assigning an additional security guard(s) to walk the areas affected. Such individuals should be specially trained in fire prevention and in occupant and fire department notification techniques, and they should understand the particular fire safety situation for public education purposes.	A2036		
A2041	19 CSR 30-85.022(16) Door Locks Door locks shall be of a type that can be opened from the inside by turning the knob or operating a simple device that will release the lock, or shall meet the requirements of Section 19.2 of NFPA 101, 2000 edition. Only one (1) lock will be permitted on any one (1) door. I/II This regulation is not met as evidenced by: Class II Based on observation and interview, the facility failed to ensure a delayed-egress exit door near resident room 30 could be opened, without delay, when the fire alarm was activated. This had the potential to affect all occupants in one of three smoke compartments in an emergency. The census was 24. Observations during the fire alarm test on 8/1/24 at 12:35 P.M., showed the delayed egress exit	A2041		

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A2041	Continued From page 15 door, near resident room 30, did not release and open without delay when the fire alarm was activated. When a code was entered into a keypad on the side of the door and pressure was applied to the door during the alarm test, the door could be opened. During an interview on 8/1/24 at 12:40 P.M., the Maintenance Director said he was not sure why the door release sequence did not activate with the fire alarm. He tested the doors monthly when he conducted fire drills and the door did not have any issues when he tested it last. The release sequence should activate when the fire alarm is activated. During an interview on 8/1/24 at 2:45 P.M., the Administrator said all egress doors should open with the activiation of the fire alarm. Maintenance staff were responsible for testing and maintaining the doors. NFPA 101, 2012, 7.1.10.1: Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	A2041		
A2054	19 CSR 30-85.022(29) Smoke Section Walls/Doors Each smoke section shall be separated by one-(1-) hour fire-rated walls that are continuous from outside wall-to-outside wall and from floor-to-floor or floor-to-roof deck. All doors in this wall shall be at least twenty- (20-) minute fire rated or its equivalent, self-closing, and may be held open only if the door closes automatically upon activation of the fire alarm system. II	A2054		

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A2054	Continued From page 16 This regulation is not met as evidenced by: Based on observation and interview, the facility failed to maintain smoke barriers to provide the required fire resistance rating. This deficient practice had the potential to affect occupants in three of three smoke compartments. The facility census was 24. Observations during the Life Safety Code tour on 8/1/24 between 7:00 A.M. and 2:00 P.M., showed the following: -In the smoke barrier wall near room 12, an approximate one inch silver conduit penetrated the wall. The space between the wall and the penetration was filled with an yellow non-fire rated material; -In the smoke barrier wall, near room 19, a white wire penetrated the wall. The space between the wall and the penetration was not sealed in any manner. An approximately 6 inch crack between the cement blocks that formed the wall was not sealed in any manner; -In the smoke barrier wall, in the corridor to the exit to the assisted living, two approximately eight inch silver pipes penetrated the wall with several silver conduits running through them. The spaces between the wall and the pipes were not sealed in any manner. The area between the conduits and the pipes were not sealed in any manner. During an interview on 8/1/24 at 8:35 A.M., the Maintenance Director said he did not know the rating of the yellow substance on the wall. It had been there a long time. He did not check the walls on a regular basis. During an interview on 8/1/24 at 2:45 P.M., the Administrator said she knew smoke walls needed	A2054		

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A2054	Continued From page 17 to be free of penetrations. Maintenance was responsible for checking and maintaining the walls. She would expect them to repair any holes in the wall. NFPA 101, 2012, 8.5.2.1: Smoke barriers required by this code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. NFPA 101, 2012, 8.5.2.2: Smoke barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces.	A2054		
A4027	19 CSR 30-85.042(23) In-service-Annually, Nursing/Restorative Facilities shall conduct at least annual in-service education for nursing personnel including training in restorative nursing. This training by a registered nurse or qualified therapist shall include: turning and positioning for the bedridden resident, range of motion (ROM) exercises, ambulation assistance, transfer procedures, bowel and bladder retraining and self-care activities of daily living. II/III This regulation is not met as evidenced by: Class III Based on interview and record review, the facility failed to ensure Certified Nurse Aides (CNAs) working in the facility received the required 12 hours of ongoing education on an annual basis. Concerns were noted in 1 of 4 employees sampled. The facility census was 24.	A4027		

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A4027	Continued From page 18 Review of the facility's "Training of Nursing Assistants" policy, revised February 2014, showed: -A performance review of each nurse aide is completed at least once every 12 months. Regular inservice is provided based on the outcome of nurse aide performance reviews. Inservice is sufficient to ensure the continuing competence of nurse aides. A minimum of 12 hours of inservice per year is provided; -The inservice program for nurse aides addresses special needs of residents as determined by the facility staff. The program includes the care of the cognitively impaired; -Nurse aides must demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in each resident's care plan. Review of the facility-provided list of active employees, showed CNA C listed with an initial hire date of 6/8/2022. 1. Review of CNA C's annual inservice and training information showed: -A hire date of 6/8/2022; -A total of 0 hours of completed annual training provided by the facility from 6/8/2023 to 6/8/2024. Review of CNA C's Individual Timecard provided by the facility showed: -CNA C worked a total of 11.25 hours on 6/21/24; -CNA C worked a total of 7.75 hours on 7/21/24. 2. During interview on 8/1/24 at 1:28 P.M. the facility Assistant Director of Nursing (ADON) said the facility does not have any current records of inservice training for CNA C, and the CNA is a PRN (as needed) staff member. CNA C has been removed from the schedule from working until	A4027		

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A4027	Continued From page 19 inservice training is completed. 3. During interview on 8/1/24 at 3:04 P.M. the facility Administrator and Director of Nursing (DON) said they would expect all CNAs to receive the required 12 hours of continuing education training on an annual basis from hire date to hire date.	A4027		
A4116	19 CSR 30-85.042(102) Clinical Records Accurate/Accessible The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices. These records shall be complete, accurately documented, readily accessible on each nursing unit, and systematically organized. II/III This regulation is not met as evidenced by: Class II* Based on interview and record review, the facility failed to adequately list accurate code statuses available to staff in the event of an emergency in the resident's medical record. Concerns were noted in 2 of 4 residents sampled. The facility census was 24. Review of the facility's "Advance Directives" policy, revised September 2013, showed: -The facility informs and provides adult residents with written information concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, to formulate an advance directive; -This includes the facility policy to implement advance directives and applicable State law.	A4116		

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A4116	Continued From page 20 -No other information was included in the advanced directives policy provided by the facility. 1. Review of Resident #2's Medical Record, showed: -An admission date of 5/31/2023; -Medical diagnoses including heart failure (failure of the heart to pump adequately oxygenated blood to the organs), atrial fibrillation (a chronic disease caused by the upper chambers of the heart pumping faster than the lower chambers), chronic kidney disease (CKD, a chronic disease caused by damaged kidneys that fail to properly filter blood through the body), and Benign Prostatic Hyperplasia (BPH, a noncancerous enlargement of the prostate causing urinary tract symptoms); -The resident was listed as DNR (Do Not Resuscitate, the preference to defer lifesaving measures in the event of a medical emergency) in the record. Review of the resident's Physician Order Sheet (POS), in use at the time of survey, showed the resident had an active physician order for DNR entered on 2/6/2024. Review of the resident's care plan, in use at the time of survey, showed: -A focus of Activities of Daily Living (ADLs, routine hygiene and self-care activities) self-care performance deficit due to limited mobility, with a goal of improving self-care performance through the next review date. Interventions included assistance with bathing activities, assistance with dressing, and assistance with self-care and grooming tasks; -A focus of terminal prognosis related to Alzheimer's (a progressive disease beginning with mild memory loss and possibly leading to	A4116		

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A4116	Continued From page 21 loss of the ability to carry on a conversation and respond to the environment), with a goal of maintaining dignity and autonomy, remaining free of depressive signs and symptoms, and maintaining resident comfort. Interventions included reviewing the resident's living will to ensure it is followed, working with the hospice team to meet physical, spiritual, and emotional needs, and to assess coping strategies and respect the resident's wishes; -No mention was made in the care plan regarding the resident's DNR status or end-of-life wishes. Review of the resident's scanned medical records, kept in a miscellaneous documents tab in each resident's record, showed: -A document indicating full code status signed by the resident's Power of Attorney (POA, a designated person to make decisions for someone in the event of incapacitation) and the facility on 5/17/2023; -A document indicating DNR status signed by the resident's POA and a licensed physician on 3/6/2024. 2. Review of Resident #3's Medical Record, showed: -An admission date of 6/14/2022; -Medical Diagnoses including neurocognitive disorder with lewy bodies (clumps of abnormal protein particles that, for reasons that are not fully understood, accumulate in the brain causing cognitive decline or impairment), bacterial pneumonia (inflammation in one or both lungs), and atherosclerotic heart disease of native arteries without angina pectoris (a buildup of plaque in the arteries of the heart that does not correlate with chest pain); -A code status of DNR.	A4116		

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A4116	Continued From page 22	A4116		

Review of the resident's POS, in use at the time of survey, showed:
-An order for DNR status signed on 7/18/2024.

Review of the resident's care plan, in use at the time of survey, showed:
-A focus of CPR code status with a goal of receiving life saving measures in the event of an emergency. Interventions included performing life saving measures if the resident were to experience a medical emergency;
-A focus of DNR code status with a goal of withholding lifesaving measures in the event of an emergency. Interventions included not performing lifesaving measures if the resident were to experience a medical emergency.

Review of the resident's scanned medical records, kept in a miscellaneous documents tab in each resident's record, showed:
-A document indicating full code status signed by the resident and the facility on 2/10/2021;
-A document indicating DNR status signed by the resident's POA and a licensed physician on 7/17/2024.

3. During interview on 8/1/24 at 2:23 P.M. CNA (Certified Nurse Aide) B said facility CNAs have access to resident's care plans, but not their orders or other specific medication administration information. CNA B would look first in a resident's care plan to verify code status in the event of a resident experiencing a medical emergency. Facility administration expects code statuses to be accurate throughout the resident's care plan in order to ensure resident wishes are honored.

4. During interview on 8/1/24 at 2:38 P.M. LPN (Licensed Practical Nurse) B said in the event of a medical emergency there is a code

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A4116	Continued From page 23 status/handoff sheet kept at the nurse's station to reference resident code statuses. LPN B would also check the resident's scanned documents for code status information, as a signed code status verifying the resident's wishes can be found in the miscellaneous tab. LPN B would expect code statuses to be updated and accurate in the resident's care plan to be referenced in the event of an emergency. During the interview, LPN B was observed flipping through the code status/handoff book at the nurse's station, and Resident #3 was listed on the document as having full code status. 5. During interview on 8/1/24 at 3:04 P.M. the facility Administrator and Director of Nursing (DON) said a resident's code status should be reflected on the face sheet in the electronic medical record, a copy of the correct code status should be uploaded into the miscellaneous documents tab, and accurate code statuses should be recorded in each resident's care plan. Facility nurses are able to access resident code statuses through the electronic medical record, and facility CNAs have access to residents' care plans to check for code statuses. The facility Administrator and DON said they would expect code statuses to be accurate and updated in resident care plans, readily available for staff to access during an emergency.	A4116		
A6012	19 CSR 30-87.020(12) Floor Surfaces All floors in the facility shall be clean and shall be maintained in good repair. Floors and floor coverings of all food-preparation, food-storage and utensil-washing areas, and the floors of all walk-in refrigerating units, dressing rooms, locker rooms, toilet rooms and vestibules shall be	A6012		

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A6012	Continued From page 24 constructed of smooth durable material such as sealed concrete, terrazzo, ceramic tile, durable grades of linoleum or plastic, or tight wood impregnated with plastic. Nothing in this section shall prohibit the use of antislip floor covering in areas where necessary for safety reasons. III This regulation is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure floors were clean in food preparation and storage areas in the facility's kitchen. The census was 24. Review of the facility's Food Service Hygiene policy, revised November 2017, showed: -Cleaning and sanitizing: --Cleaning jobs are assigned to each person on a daily, weekly, or monthly basis; --Procedures for cleaning all equipment and work areas are established. Observations on 8/1/24 at approximately 7:59 A.M., 9:18 A.M., and 11:29 A.M., showed dark grey grime on the floor, along the perimeter of the kitchen and underneath preparation tables and kitchen equipment, including the ice machine, oven, deep fryer, standing mixer, and gas range. Dark grey grime was on the floor underneath the wire shelving units in the dry storage area. Crumbs and food debris were on the floor surrounding the standing mixer and underneath the deep fryer and oven. Food debris, including the skin of onions and smashed asparagus stalks, were along the floor of the walk-in cooler. Yellowed sheets of ice and food debris, including frozen peas, were on the floor in the walk-in freezer. During an interview on 8/1/24 at approximately 11:35 A.M., Cook A said the kitchen is short on	A6012		

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A6012	Continued From page 25 staff. Cooks clean the kitchen as they go. There is no specific cleaning schedule and there is no deep cleaning schedule. During an interview on 8/1/24 at approximately 9:40 A.M., the Executive Chef (EC) said the kitchen does not have a set cleaning schedule. The kitchen is short on staff. Cooks clean the kitchen every night. On Sunday, the kitchen has an extra dishwasher to help with spot cleaning. The kitchen does not have a deep cleaning schedule. Deep cleaning in the kitchen is done maybe once a year. During an interview on 8/1/24 at 11:42 A.M., the EC said he sees the grime on the floors and they should be cleaned. The kitchen floors are mopped by dietary staff every night. They used to have a floor tech who did the kitchen floors every Monday, but they don't anymore. He needs to get a deep cleaning schedule together. During an interview on 8/1/24 at 3:06 P.M., the Administrator said she expected floors throughout the kitchen to be clean and free from debris and grime. She expected the walk-in coolers to be free from debris. She expected the kitchen to have a routine cleaning schedule and a deep cleaning schedule, to be followed by staff.	A6012		
A6015	19 CSR 30-87.020(15) Walls/Ceilings/Doors/Windows Clean Walls and ceilings, including doors, windows and skylights, shall be clean and maintained in good repair. III This regulation is not met as evidenced by: Based on observation, interview and record	A6015		

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A6015	Continued From page 26	A6015		

review, the facility failed to ensure walls and ceilings were clean in food preparation areas in the facility's kitchen. The census was 24.

Review of the facility's Food Service Hygiene policy, revised November 2017, showed:
-Cleaning and sanitizing:
--Cleaning jobs are assigned to each person on a daily, weekly, or monthly basis;
--Procedures for cleaning all equipment and work areas are established.

Observation on 8/1/24 at approximately 7:59 A.M., showed dust on the ceiling vents above the tabletop mixer and above the prep counter in the back of the kitchen, across from the deep fryer and oven. Dust was on the ceiling in front of the gas range. Dust was on the ceiling vents above the prep counter and sink in front of the dry storage room. Dust was on the wall above the door to the dry storage room.

During an interview on 8/1/24 at approximately 11:35 A.M., Cook A said the kitchen is short on staff. Cooks clean the kitchen as they go. There is no specific cleaning schedule and there is no deep cleaning schedule.

During an interview on 8/1/24 at approximately 9:40 A.M., the Executive Chef (EC) said the kitchen does not have a set cleaning schedule. The kitchen is short on staff. Cooks clean the kitchen every night. On Sunday, the kitchen has an extra dishwasher to help with spot cleaning. The kitchen does not have a deep cleaning schedule. Deep cleaning in the kitchen is done maybe once a year.

During an interview on 8/1/24 at 11:42 A.M., the EC said he sees the dust on the ceilings and

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCKNIGHT PLACE ASSISTED LIVING AND MEMORY	THREE MCKNIGHT PLACE SAINT LOUIS, MO 63124

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A6015	Continued From page 27 walls and this should be cleaned. He needs to get a deep cleaning schedule together. During an interview on 8/1/24 at 3:06 P.M., the Administrator said she expected walls and ceilings in the kitchen to be clean and free from dust and debris. She expected the kitchen to have a routine cleaning schedule and a deep cleaning schedule, to be followed by staff.	A6015		
A7015	19 CSR 30-87.030(13) Food-Protected, Temp, Need to Contact DHSS At all times, including while being stored, prepared, displayed, served or transported to or from the facility, food shall be protected from potential contamination, including dust, insects, rodents, unclean equipment and utensils, unnecessary handling, coughs and sneezes, flooding, drainage and overhead leakage or overhead drippage from condensation. The temperature of potentially hazardous food shall be forty-five degrees Fahrenheit (45°F) or below or one hundred forty degrees Fahrenheit (140°F) or above at all times, except as otherwise provided in this section. In the event of a fire, flood, power outage or similar event that might result in the contamination of food, or that might prevent potentially hazardous food from being held at required temperatures, the person in charge shall immediately contact the Department of Health and Senior Services (the department). Upon receiving notice of this occurrence, the department shall take whatever action that it deems necessary to protect the residents. II/III This regulation is not met as evidenced by: Class II*	A7015		

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A7015	Continued From page 28 Based on observation, interview and record review, the facility failed to ensure food was appropriately stored and protected from potential contamination. The census was 24. Review of the facility's Food Service Hygiene policy, revised November 2017, showed: -All staples are stored in sealed or tightly covered containers; -All products are stored above the floor to ensure proper cleaning of the floor underneath and to protect the food from any back flow of water; -Leftovers are properly labeled and dated for identification; Observations on 8/1/24 at approximately 7:59 A.M., showed: -A bulk bin of panko breadcrumbs with the scoop inside the bin, with the handle touching the breadcrumbs; -The walk-in cooler with a wired shelving unit with a sign posted, "Raw Meat Only." Two pans of a cooked meat, loosely covered in plastic wrap with a small gap on one side, on the shelf, underneath a shelf containing a box of raw meat. On top of a cardboard box, a slab of raw meat partially wrapped in aluminum foil, leaving an area approximately two inches (in.) by six in. exposed. Red liquid pooled on top of an opened cardboard box underneath the shelf containing the raw meat which was partially wrapped in aluminum foil; -The dry storage area with four cardboard boxes that contained potatoes. Dozens of gnats crawled over the potatoes in two of the cardboard boxes. A bulk container of onion powder had no lid. A white bin containing lentils with no lid. A bag of spaghetti noodles and a bag of penne noodles, open and unwrapped, with no label to show open date. Gnats flew throughout the dry storage room;	A7015		

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A7015	Continued From page 29	A7015		

-The walk-in freezer with five stacks of boxes of food, some opened, on the freezer floor. One stack of boxes was on top of a sheet of ice on the freezer floor. Sixteen bags of miscellaneous breads were undated. One clear trash bag was filled with pitas, open, unwrapped, and undated. An uncovered cookie sheet contained unidentifiable breaded frozen meats with a metal tin stacked directly on top of the frozen meats. An open, unwrapped bag of crinkle cut fries, was undated, and an open, unwrapped bag of onion rings was undated. An open bag of unidentifiable breaded square-shaped food items and an open bag of unidentifiable breaded circular-shaped food items, was undated and unlabeled, on top of a cookie sheet containing bread rolls, unwrapped and undated. An open bag of frozen peas was undated, spilling out of the bag and into the boxes and onto the floor underneath the bag. Approximately five bags of miscellaneous meats, including chicken tenders, were coated in frostbite.

Observations on 8/1/24 at approximately 9:18 A.M., showed:
-A bulk bin of panko breadcrumbs with the scoop inside the bin with the handle touching the breadcrumbs;
-The walk-in cooler with wired shelving unit with boxes containing raw meat. The sign posted, "Raw Meat Only," the tins of cooked meat, and the slab of meat partially wrapped in aluminum foil, observed at 7:59 A.M., were no longer in the cooler. Red liquid remained pooled on top of an opened cardboard box;
-The dry storage area with four cardboard boxes contained potatoes. Dozens of gnats crawled over the potatoes in two of the cardboard boxes. A bulk container of onion powder had no lid. A white bin containing lentils with no lid. A bag of

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A7015	Continued From page 30 spaghetti noodles and a bag of penne noodles, open and unwrapped, with no label to show open date. Gnats flew throughout the dry storage room; -The walk-in freezer with five stacks of boxes of food, some opened, on the freezer floor. One stack of boxes on top of a sheet of ice on the freezer floor. Sixteen bags of miscellaneous breads, undated. One clear trash bag was filled with pitas, open, unwrapped, and undated. An uncovered cookie sheet containing unidentifiable breaded frozen meats with a metal tin was stacked directly on top of the frozen meats. An open, unwrapped bag of crinkle cut fries, was undated, and an open, unwrapped bag of onion rings was undated. An open bag of unidentifiable breaded square-shaped food items and an open bag of unidentifiable breaded circular-shaped food items, was undated and unlabeled, on top of a cookie sheet containing bread rolls, unwrapped and undated. An open bag of frozen peas was undated, spilling out of the bag and into the boxes and onto the floor underneath the bag. Approximately five bags of miscellaneous meats, including chicken tenders, was coated in frostbite. During an interview on 8/1/24 at approximately 9:30 A.M., the Executive Chef (EC) said most of the boxes on the floor of the walk-in freezer had been there since last Tuesday, and some of the other boxes had been on the floor since yesterday. The boxes should be stored off the floor. Food shipments can come in daily. Whomever is working in dietary can receive the food shipment and the EC and Sous Chef are responsible for stocking the food when it is received. When a food item is opened, it should be wrapped, dated, and labeled, before it is stored. He saw gnats in the kitchen and he thought they were coming from the potatoes.	A7015		

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A7015	Continued From page 31 Observations on 8/1/24 at approximately 11:29 A.M., showed: -The walk-in freezer with five stacks of boxes of food, some opened, on the freezer floor. One stack of boxes was on top of a sheet of ice on the freezer floor. Sixteen bags of miscellaneous breads, were undated. One bag filled with pitas, was open, unwrapped, and undated. An uncovered cookie sheet containing unidentifiable breaded frozen meats with a metal tin was stacked directly on top of the frozen meats. An open, unwrapped bag of crinkle cut fries was undated, and an open, unwrapped bag of onion rings, was undated. An open bag of unidentifiable breaded square-shaped food items and an open bag of unidentifiable breaded circular-shaped food items were undated and unlabeled, on top of a cookie sheet containing bread rolls, unwrapped and undated. An open bag of frozen peas was undated, spilling out of the bag and into the boxes and onto the floor underneath the bag. Approximately five bags of miscellaneous meats, including chicken tenders, was coated in frostbite; -A bulk bin of panko breadcrumbs with the scoop inside the bin with the handle touching the breadcrumbs; -The dry storage area with four cardboard boxes containing potatoes. Dozens of gnats crawled over the potatoes in two of the cardboard boxes. A bulk container of onion powder had no lid. A white bin containing lentils with no lid. A bag of spaghetti noodles and a bag of penne noodles, were open and unwrapped, with no label to show open date. Gnats flew throughout the dry storage room. During an interview on 8/1/24 at approximately 11:35 A.M., Cook A said the scoops for the dry	A7015		

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A7015	Continued From page 32 food bins should be stored in the slot for each bin, not inside the bin where it touches the food, due to contamination. Opened food items should be wrapped, dated, and labeled before they are stored. During an interview on 8/1/24 at 11:42 A.M., the EC said the scoop for the dry food storage bins should be kept in the slot for each bin, not inside the bin where it touches food. Dietary staff should wrap, date, and label all foods that have been opened. Food should be stored in a way to prevent contamination. It is not appropriate to store unwrapped and uncovered items in the walk-in cooler, freezer, or dry storage area. During an interview on 8/1/24 at 3:06 P.M., the Administrator said she expected scoops in dry storage bins to be stored separately so it is not touching food. All opened foods should be wrapped, dated, and labeled. Bulk storage of spices and dry goods should be in closed containers. Frostbitten foods in the walk-in freezer should be discarded. She is unaware of a pest issue in the kitchen. If dietary staff suspect a specific food, such as potatoes, are a source of gnats or flies, it is expected the food be discarded and replaced.	A7015		
A7067	19 CSR 30-87.030(65) Nonfood Contact Surfaces,Cleaned as Needed Nonfood-contact surfaces of equipment shall be cleaned as often as is necessary to keep the equipment free of accumulation of dust, dirt, food particles and other debris. III This regulation is not met as evidenced by: Based on observation, interview and record	A7067		

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A7067	Continued From page 33	A7067		

review, the facility failed to ensure nonfood-contact surfaces of equipment were clean in the facility's kitchen. The census 24.

Review of the facility's Food Service Hygiene policy, revised November 2017, showed:
-Cleaning and sanitizing:
--Cleaning jobs are assigned to each person on a daily, weekly, or monthly basis;
--Procedures for cleaning all equipment and work areas are established.

Observations on 8/1/24 at approximately 7:59 A.M. and 9:18 A.M., showed
-Crumbs of varying colors along the back and sides of the deep fryer;
-Dried dark brown splatter along the front and sides of the deep fryer;
-A standing mixer, uncovered, with chunks of beige crumbs covering the area behind the bowl and around the base of the machine;
-Crumbs and dried food debris on the bottom shelf affixed to the oven;
-Dark brown splatter on the front of the gas range.

During an interview on 8/1/24 at approximately 11:35 A.M., Cook A said the kitchen is short on staff. Cooks clean the kitchen as they go. There is no specific cleaning schedule and there is no deep cleaning schedule. The mixers should be covered when they are not in use, but they do not have covers for the mixers.

During an interview on 8/1/24 at approximately 9:40 A.M., the Executive Chef (EC) said the kitchen does not have a set cleaning schedule. The kitchen is short on staff. Cooks clean the kitchen every night. On Sunday, the kitchen has an extra dishwasher to help with spot cleaning.

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A7067	Continued From page 34 The kitchen does not have a deep cleaning schedule. Deep cleaning in the kitchen is done maybe once a year. During an interview on 8/1/24 at 11:42 A.M., the EC said he expects the mixers to be covered when not in use. The staff used to do this and he is unsure why they fell off. He needs to get a deep cleaning schedule together. During an interview on 8/1/24 at 3:06 P.M., the Administrator said she expected kitchen equipment to be clean. She expected mixers to be covered when not in use. She expected the kitchen to have a routine cleaning schedule and a deep cleaning schedule, to be followed by staff. *The higher classification merited due to the extent of the violation.	A7067		

PLAN OF CORRECTION

Provider/Supplier Name:	McKnight Place Assisted Living & Memory Care
Street Address, City, Zip:	#3 McKnight Place, Saint Louis MO 63124
Date of Survey:	08/01/2024

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
A 2010	Full and Empty oxygen tanks were sorted and stored separately on 8/1/2024. Bins of plastic oxygen tubing and supplies were removed from the closet on 8/1/2024. Plastic cart removed from the closet on 8/1/2024. Plastic biohazard bags were removed from the closet on 8/1/2024. Maintenance, Nursing, and Central Supply staff re-educated regarding proper Oxygen cylinder storage requirements according to the NFPA Code. Director of Nursing or Designee to conduct a visual inspection of the Oxygen room 5x/week for 4 weeks to ensure items are stored appropriately and to NFPA code. Upon completion of the initial 4 week inspections, Maintenance Director or Designee will continue to monitor via visual inspection of the room 1x/week for 3 months. Visual inspections will be documented on an inspection log with a date and signature of the individual(s) conducting the inspection. Results of monitoring and/or audits will be brought to facility's QA meeting for IDT review to identify further monitoring and/or corrective action needs to be taken.	09/15/2024
A 2016	Fire extinguishers were replaced by Fire Safety, Inc. with replacement extinguisher measurements not exceeding the 60 inches (5 foot) limit on 8/3/24. Maintenance staff re-educated regarding the NFPA 10 requirement of fire extinguishers not to exceed 60 inches above the finished floor.	09/15/2024

	Maintenance Director or Designee to condict and document monthly visual check of fire extinguishers to ensure they are installed and maintained in accordance with NFPA 10 monthly x 3 months. Results of monitoring and/or audits will be brought to facility's QA meeting for IDT review to identify further monitoring and/or corrective action needs to be taken.	
A 2025	Facility updated Fire Watch Policy & Procedure to include: • Notification of DHSS & Local Fire Authority in the event the fire alarm system is to be out of service for more than of our (4) hours in a twenty four (24) hour period as well as notification of when service is restored. • Includes the contact information of the appropriate entities. • Staff are trained on fire watch procedures to include having no other duties during their fire watch, and observing all exits, and the exterior of the building; and fire prevention and communication methods in the event of an emergency. • Directions to staff to post a tag at each fire department connection, the system control valve, and other locations required by University City FPD, indicating which system or part thereof has been removed from service. Staff educated on fire watch policy updates and procedures. Maintenance Director or Designee to review documentation of any Fire Watch event to proper adherence to Facility's Fire Watch Policy & Procedure. Results of monitoring and/or audits will be brought to facility's QA meeting for IDT review to identify further monitoring and/or corrective action needs to be taken.	09/15/2024
A 2034	Ahern Fire Protection completed repairs to Sprinkler System on 8/2/24. Maintenance Director reviewed annual sprinkler inspection for further identification of repairs needed, with repairs scheduled as appropriate. Maintenance re-educated regarding timeliness of repairs when deficiencies are found. Maintenance Director or Designee to Sprinkler System monitor work orders weekly x 4 weeks for timeliness & documentation of completion.	09/15/2024

	Results of monitoring and/or audits will be brought to facility's QA meeting for IDT review to identify further monitoring and/or corrective action needs to be taken.	
A 2036	Facility updated Fire Watch Policy & Procedure to include: • Notification of DHSS & Local Fire Authority in the event the fire alarm system is to be out of service for more than of our (4) hours in a twenty four (24) hour period as well as notification of when service is restored • Includes the contact information of the appropriate entities. • Staff are trained on fire watch procedures to include having no other duties during their fire watch, and observing all exits, and the exterior of the building; and fire prevention and communication methods in the event of an emergency. • Staff are to post a tag at each fire department connection, the system control valve, and other locations required by University City FPD, indicating which system or part thereof has been removed from service. Staff educated on fire watch policy updates and procedures. Maintenance Director or Designee to review documentation of any Facility Fire Watch event for adherence to compliance with Policy and Procedure updates. Results of monitoring and/or audits will be brought to facility's QA meeting for IDT review to identify further monitoring and/or corrective action needs to be taken.	09/15/2024
A 2041	Tech Electronics repaired egress door module on 8/2/24 and verified functionality. Maintenance staff re-educated regarding ensuring delayed egress doors can be opened, without delay, when the fire alarm is activated. Maintenance Director or Designee to test egress doors to ensure they open without delay upon activation of the fire alarm weekly x 4 weeks and monthly x 3 months thereafter. Tests will be documented on a testing log with a date and signature of the individual(s) conducting the test. Results of monitoring and/or audits will be brought to facility's QA meeting for IDT review to identify further monitoring and/or corrective action needs to be taken.	09/15/2024
A 2054	Smoke barrier wall penetrations near rooms 12, 19, and in the corridor to the assisted living were corrected on 8/1/24 by Maintenance Staff. Maintenance staff re-educated regarding maintaining smoke barriers to provide the required fire resistance rating.	09/15/2024

	Maintenance Director or Designee to conduct a monthly visual inspection of smoke barrier walls for areas of penetration, and to correct as identified. Visual inspections will be documented on an inspection log with a date and signature of the individual(s) conducting the inspection. Results of monitoring and/or audits will be brought to facility's QA meeting for IDT review to identify further monitoring and/or corrective action needs to be taken.	
A 4027	Facility removed CNA from schedule until required 12 hours of ongoing training has been completed. Business Office Director or Designee to audit active nursing education files, with any employee out of compliance being removed from the facility staffing scheduled until corrected. Business Office Director, Director of Nursing re-educated regarding the annual in-service education requirement for nursing personnel. Business Office Director or Designee to audit CNA education documentation monthly for compliance x 6 months, and semiannually thereafter. Results of monitoring and/or audits will be brought to facility's QA meeting for IDT review to identify further monitoring and/or corrective action needs to be taken.	09/15/2024
A 4116	Residents #2 and #3 code statuses were corrected to reflect accurately in their medical record. Director of Nursing or Designee to audit in-house Memory Care resident code statuses and documentation of POS to ensure resident code statuses are accurately documented in their medical record. Nursing staff re-educated regarding documentation of code statuses to include changes in code status. Director of Nursing or Designee to audit 5 sample resident medical records weekly x 4 weeks for accurate code status documentation, and monthly thereafter x 3 months to ensure nursing staff are documenting and reflecting accurate resident code statuses. Results of monitoring and/or audits will be brought to facility's QA meeting for IDT review to identify further monitoring and/or corrective action needs to be taken.	09/15/2024
A 6012	Kitchen floors received deep cleaning from facility floor technicians. Food Service and Housekeeping staff re-educated regarding facility's Food Service Hygiene policy, and facility's food service cleaning schedule.	09/15/2024

	Housekeeping staff assigned to provide weekly and as needed deep floor cleaning to ensure floors are clean in food preparation and storage areas of the kitchen. Executive Chef or Designee to visually inspect kitchen and storage room floors for cleanliness and identification of additional cleaning needs 5 days/week x 3 months and weekly x 3 months thereafter to ensure routine cleaning is performed and effective. Results of monitoring and/or audits will be brought to facility's QA meeting for IDT review to identify further monitoring and/or corrective action needs to be taken.	
A 6015	Executive Chef or Designee cleaned dust from: • ceiling vents above the tabletop mixer • above the prep counter in the back of the kitchen • on ceiling vents above the prep counter and sink in front of the dry storage room (in front of the dry storage room) • the wall above the door to the dry storage room Executive Chef or Designee visually inspected kitchen and dry storage areas for additional cleaning/dust removal needs and issues identified were corrected immediately. Executive Chef and Dining Services Staff re-educated regarding kitchen cleaning schedule, assignments and checklist. Executive Chef or Designee to visually inspect Kitchen and Kitchen Dry Storage walls, ceilings, doors, windows to ensure they are clean and maintained in good repair 5x per week for 3 months, and weekly x 3 months thereafter. Results of monitoring and/or audits will be brought to facility's QA meeting for IDT review to identify further monitoring and/or corrective action needs to be taken.	09/15/2024
A 7015	Executive Chef or Designee immediately removed scoop from bin of panko breadcrumbs on 8/1/24. Executive Chef or Designee removed meat improperly stored meat products from walk-in cooler and ensured proper sealing/coverage and storage on 8/1/24. Executive Chef or Designee inspected walk-in freezer and removed and discarded food items that were opened and undated, unlabeled, improperly covered, or frost-bitten food items. Executive Chef or Designee visually inspected dry storage and walk ins for further identification of improperly stored or labeled food items and corrected identified issues immediately.	09/15/2024

	Dining Services staff re-educated on proper storage and labeling of food products, and proper notification of DHSS in the event of an outage that may result in the contamination of food. Executive Chef or Designee to visually inspect food storage areas to include walk-in coolers, walk-in freezer, shelves, and dry storage for proper storage and labeling of food items 5x per week x 3 months and weekly x 3 months thereafter. Results of monitoring and/or audits will be brought to facility's QA meeting for IDT review to identify further monitoring and/or corrective action needs to be taken.	
A 7067	Deep fryer was removed from service and cleaned thoroughly by Executive Chef or Designee on 8/1/24. Stand mixer was removed from service and cleaned thoroughly by Executive Chef or Designee on 8/1/24. Oven shelf was cleaned thoroughly by Executive Chef or Designee on 8/1/24. Gas range was cleaned thoroughly by Executive Chef or Designee on 8/1/24. Dining Services staff re-educated regarding Food Service Hygiene policy and kitchen cleaning assignments, cleaning of kitchen equipment, schedule, and checklists. Executive Chef or Designee to visually inspect Kitchen and Kitchen Dry Storage walls, ceilings, doors, windows to ensure they are clean and maintained in good repair 5x per week for 3 months, and weekly x 3 months thereafter. Results of monitoring and/or audits will be brought to facility's QA meeting for IDT review to identify further monitoring and/or corrective action needs to be taken.	09/15/2024

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.