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
	07481B	A. BUILDING: _____ B. WING _____	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST AGNES HOME	10341 MANCHESTER ROAD KIRKWOOD, MO 63122

(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
A2008	19 CSR 30-85.022(4) Hazardous Areas Hazardous areas shall be separated by construction of at least one- (1-) hour fireresistant construction. Hazardous areas may be protected by an automatic sprinkler system in lieu of a one- (1-) hour rated fire-resistant construction. When the sprinkler option is chosen, the areas shall be separated from other spaces by smoke-resistant partitions and doors. The doors shall be self-closing or automatic closing. II This regulation is not met as evidenced by: Based on observation and interview, the facility failed to maintain hazardous areas with smoke-resistant doors equipped with self-closing devices. This deficiency had the potential to affect occupants on one of four resident-occupied floors. The facility had a census of 97. 1. Observation on 6/12/25 at 8:40 A.M., of the medical records room, showed the following: -On one wall, six shelves contained approximately 14 cardboard boxes of records; -On another wall, three shelves contained eight cardboard boxes of records; -The room was over 50 square feet; -No self-closer on the door from the room to the corridor. During an interview on 6/12/25 at 8:40 A.M., the Maintenance Supervisor said the door never had a self-closer. 2. Observation on 6/12/25 at 8:50 A.M., of the clean biohazard utility room, showed the following: - On one wall, five shelves contained approximately 20 cardboard boxes of supplies and briefs;	A2008	Angela Rupp, Administrator	7/7/25

Missouri Department of Health and Senior Services
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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A2008	Continued From page 1 -On another wall, five shelves contained approximately 15 cardboard boxes of supplies and sponges; -An additional 20 cardboard boxes on a cart; -The room was over 50 square feet; -No self-closer on the door from the room to the corridor, and the door did not latch. During an interview on 6/12/25 at 8:50 A.M., the Maintenance Supervisor said the door never had a self-closer. 3. Observation on 6/12/25 at 9:20 A.M., of the activity storage room, showed the following: -On one wall of the room, four shelves contained multiple plastic bins and cardboard boxes of decorations and activity supplies; -On another wall of the room, four shelves contained multiple plastic bins and cardboard boxes of decorations and activity supplies; -On the other wall, two cabinets of supplies; -The room was over 50 square feet; -The bottom of the door had a vented area, approximately 3 by 1 feet in area; -No self-closer on the door from the room to the corridor. 4. Observation on 6/12/25 at 9:30 A.M., of the dietary paper goods storage room, showed the following: -On one wall, four shelves of paper supplies; -On another wall, four shelves of paper supplies; -The room was over 50 square feet; -Ten, approximately 1 inch holes in the upper panel of the door; -The door was equipped with a self-closing device. During an interview on 6/12/25 at 9:30 A.M., the Maintenance Supervisor said he did not know	A2008		

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A2008	Continued From page 2 why the door had multiple holes.	A2008		
A2013	19 CSR 30-85.022(8)(B) Fire Extinguishers-ABC/K Rated Fire Extinguishers. (B) All new or replacement portable fire extinguishers shall be ABC-rated extinguishers, in accordance with the provisions of NFPA 10, 1998 edition. A K-rated extinguisher or its equivalent shall be used in lieu of an ABC-rated extinguisher in the kitchen cooking areas. II This regulation is not met as evidenced by: Based on observation and interview, the facility failed to ensure portable fire extinguishers were maintained in accordance with requirements of NFPA 10 in one of two kitchens. This deficient practice had the potential to affect all occupants in two of 23 smoke compartments. The facility had a census of 97 residents. Observation on 6/12/25 at 7:00 A.M., showed the main floor kitchen featured a range hood suppression system over the cooking equipment. A K-class fire extinguisher hung on a bracket on the wall. No signage was posted near the extinguisher prompting staff to actuate the range suppression system prior to using the K-class extinguisher. During an interview on 6/12/25 at 1:45 P.M., the Maintenance Supervisor said when the contracted company came to service the fire extinguishers in April, they said they would bring a placard for the K-class extinguisher in the main floor kitchen, but they have not supplied it to the facility yet.	A2013		

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A2013	Continued From page 3 NFPA 10 (2010) 5.5.5* Class K Cooking Media Fires. 5.5.5.3* A placard shall be conspicuously placed near the extinguisher that states that the fire protection system shall be actuated prior to using the fire extinguisher.	A2013		
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 maintain all doors in an exit pathway without a lock that required special knowledge. This deficiency had the potential to affect all occupants in one of 23 smoke compartments. The census was 97. Observation on 6/12/25 at 9:50 A.M., of the door from the second floor rotunda area area to the convent, showed the following: -A lit exit sign above the door; -The door locked but equipped with an electronic keypad; -The code was not posted above the keypad; -No delayed egress mechanism on the door to open the door within 15 seconds if pushed. During an interview on 6/12/25 at 9:50 A.M., the Maintenance Supervisor said he could not open the exit door to the convent. He did not have a	A2041		

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A2041	Continued From page 4 key and did not know the code. Observation on 6/12/25 at 9:55 A.M., of the evacuation diagram posed on the second floor, showed the exit door to the convent as part of the evacuation route for the smoke compartment. Observation on 6/12/25 at 10:05 A.M., showed the second floor exit door to the convent released with the fire alarm. During an interview on 6/12/25 at 1:30 P.M., the Administrator said the residents on the second floor needed the assistance of one staff member or less with care, and they did not need the safety of the Care Center (lower level). The residents on floors one through three did not have elopement concerns.	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 This regulation is not met as evidenced by: Based on observation and interview, the facility failed to ensure all smoke barrier doors close upon activation of the fire alarm. This deficiency had the potential to affect all occupants in six of 23 smoke compartments in the event of a fire.	A2054		

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A2054	Continued From page 5 The facility had a census of 97 residents. Observation on 6/12/25 at 10:05 A.M., showed the Maintenance Supervisor activated the fire alarm: -At the smoke barrier between the first floor main dining room and the resident halls, the smoke barrier doors released from the magnets, but one of the doors remained open approximately 3 inches, and the door did not close flush; -At the smoke barrier near room 208, the smoke barrier doors released from the magnets, but one of the two doors in the set remained completely open; -At the smoke barrier near room 305, the smoke barrier doors released from the magnets, but one of the two doors in the set remained completely open. During an interview on 6/12/25 at 10:30 A.M., the Maintenance Supervisor said for some of the doors, the doors are too heavy for the hinges, which caused some of the doors not to close properly. They are obtaining bids to have all the needed hinges replaced, but the work has not been scheduled yet.	A2054		
A2061	19 CSR 30-85.022(33)(D) Fire Drill Requirements, Evacuation (D) A minimum of twelve (12) fire drills shall be conducted annually with at least one (1) every three (3) months on each shift. At least four (4) of the required fire drills must be unannounced to residents and staff, excluding staff who are assigned to evaluate staff and resident response to the fire drill. The fire drills shall include a simulated resident evacuation that involves the local fire department or emergency service at	A2061		

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A2061	Continued From page 6 least once a year. II/III This regulation is not met as evidenced by: Class II* Based on interview and record review, the facility failed to conduct fire drills, once per shift every quarter, for two of four quarters reviewed. This deficiency had the potential to affect all building occupants in the event of a fire. The facility had a census of 97 residents. Review of the facility's fire drills for the last four quarters showed: -No third shift drill conducted during the third quarter of 2024; -No second and third shift drills conducted during the first quarter of 2025. During an interview on 6/12/25 at 1:30 P.M., the Maintenance Supervisor said he did not conduct the drills that occurred during the night shift. Night shift drills were led by one of the night shift charge nurses, and the nurses were supposed to provide him with the paperwork when completed. He did not always get the paperwork, and will check to see if there is any other documentation for the missing drills. *The higher classification merited due to the extent of the violation.	A2061		
A4054	19 CSR 30-85.042(45) Written Orders; Restraints No medication, treatment, or diet shall be given without a written order from a person lawfully authorized to prescribe such and the order shall be followed. No restraint shall be applied except as provided in 13 CSR 15-18.010, Resident	A4054		

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A4054	Continued From page 7 Rights. I/II This regulation is not met as evidenced by: Class II Based on observation, interview and record review, the facility failed to follow the physician orders for medication, for one of seven sampled residents (Resident #3). The census was 97. Review of Resident #3's face sheet, showed his/her diagnoses included hypertension (high blood pressure), hypothyroidism (underactive thyroid disease) and benign prostatic hyperplasia (BPH, enlargement of the prostate gland). Review of the physician's orders, dated 5/29/25 at 12:38 P.M., showed propranolol (treats high blood pressure) 20 milligrams (mg) tablet, give one tablet (20 mg) by oral route two times per day. Review of the nurse's note, dated 5/29/25 at 12:58 P.M., showed the resident returned from the hospital a little after noon today. He/She is doing well and is glad to be back. He/She came back with the following orders: Ceftin (antibiotic) 250 mg every 12 hours times 7 days, propranolol was changed to 20 mg two times per day (BID), Zofran 4 mg needed (PRN) for nausea and Robitussin 10 ml PRN every 6 hours for cough. All orders have been verified with nurse practitioner. Observation on 6/12/25 at 8:20 A.M., showed Certified Medication Technician (CMT) A removed a pill from the medication card for the resident, and placed it in a medication cup. The CMT gave the medication cup to the resident, and he/she swallowed the pill. Review of the medication card, showed propranolol 40 mg.	A4054		

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A4054	Continued From page 8 During an interview on 6/12/25 at 10:40 P.M., CMT A reviewed the orders. He/She said the order was for propranolol 20 mg, give one tablet two times per day. CMT A said the card showed 40 mg. CMT A called the pharmacy, who said they had orders for 20 mg and 40 mg, but had not sent to the facility any cards with 20 mg. The order in February 2025 was 40 mg, but the order was changed on 5/29/25 to 20 mg. CMT A said the order was not changed and the 40 mg dose needed to be discontinued. During an interview on 6/12/25 at 10:45 A.M., Licensed Practical Nurse (LPN) B said the order read propanolol 20 mg two times per day. The resident should have received 20 mg at the time of the medication pass. During an interview on 6/12/25 at 2:00 P.M., the Director of Nurses said the nurse should take the order off and put a new order in, and take the previous card off the cart. The new order should be faxed to the pharmacy.	A4054		

PLAN OF CORRECTION

Provider/Supplier Name:	St Agnes Home
Street Address, City, Zip:	10341 Manchester Road Kirkwood, MO 63122
Date of Survey:	6/12/25

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

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A2008	19 CSR 30-85.022(4) Hazardous Areas Corrective Action: 1. Self Closure installed on Medical Records Room door 2. Self Closure installed on Clean Biohazard Utility Room door 3. Vented area on Activity Storage Room door covered with sheet metal 4. Self Closure installed on Activity Storage Room door 5. Vented area on Dietary Paper Goods Storage Room door covered with sheet metal 6. All doors will be checked monthly by Maintenance to ensure the self-closures are operating properly, in addition doors will be checked to ensure there are not any holes in the doors and this will be overseen by the Administrator 7. Inservice for all staff on why doors have self-closures, how they operate, and where those doors are located	**Completed by 8/1/25**
A2013	19 CSR 30-85.022(8)(B) Fire Extinguishers-ABC/K Rated Corrective Action: 1. Portable Fire Extinguisher in place and Placard placed above Fire Extinguisher in Main Kitchen that reads “In case of appliance fire, use this extinguisher only after fixed suppression system has been actuated” 2. Placard placement will be checked monthly by Maintenance to ensure signage is in place and this will be overseen by the Administrator 3. Inservice for Maintenance and Dietary Staff on the Placards placement and reason for them	**Completed by 8/1/25**

A2041	19 CSR 30-85.022(16) Door Locks Corrective Action: 1. Device installed to release the lock on the 2nd floor, west end rotunda door 2. Egress device will be tested monthly by Maintenance Director to ensure it operates properly and this will be overseen by Administrator 3. Inservice with all staff on how delayed egress mechanisms work on doors, as well as the locations for these doors	**Completed by 8/1/25**
A2054	19 CSR 30-85.022(29) Smoke Section Walls/Doors Corrective Action: 1. Door near room 208 had the sweeps removed, cleaned and reinstalled to ensure door properly shuts completely 2. Door near room 305 had the sweeps removed, cleaned and reinstalled to ensure door properly shuts completely 3. Hinges needed for doors that need new ones replaced 4. Doors sweeps and hinges will be checked monthly by the Maintenance Department to ensure the doors close completely and hinges work properly, as this will be overseen by Administrator 5. Inservice with all Staff on location of fire doors and their operations, including sweeps and hinges	**Completed by 9/1/25**
A2061	19 CSR 30-85.022(33)(D) Fire Drill Requirements, Evacuation Correction Action: 1. Third shift drill was conducted during the third quarter of 2024 – **see attached** 2. Second and Third shift drills conducted during the first quarter of 2025 – **see attached** 3. Fire Drills will be conducted by the Maintenance Department and records will be placed in Fire Drill Binder under supervision of Administrator	**Completed by 7/7/25**
A4054	19 CSR 30-85.042(45) Written Orders; Restraints Corrective Action: 1. Pharmacy informed of the medication error 2. Nurses will remind CMTs each shift on the Audit Form to check if any medication changes were made and this will be done under supervision of Director of Nursing 3. Inservice with Nurses on importance of when given a new order to take off prior order, remove previous medication card off the cart, and fax new order to the pharmacy 4. Inservice with CMTs and Nurses on checking the orders before giving residents medication	**Completed by 8/1/25**

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.