

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 11784C	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/13/2010
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NAME OF PROVIDER OR SUPPLIER K F JAMMER MANOR, WEST	STREET ADDRESS, CITY, STATE, ZIP CODE 1004 PENNSYLVANIA SAINT LOUIS, MO 63130
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A2229 19 CSR 30-86 .022(7)(E)	<p>(E) If it is necessary to lock exit doors, the locks shall not require the use of a key, tool, special knowledge, or effort to unlock the door from inside the building. Only one (1) lock shall be permitted on each door. Delayed egress locks complying with section 7.2.1.6.1 of the 2000 edition NFPA 101 shall be permitted, provided that not more than one (1) such device is located in any egress path. Self-locking exit doors shall be equipped with a hold-open device to permit staff to reenter the building during the evacuation. /II</p> <p>This regulation is not met as evidenced by: Class II</p> <p>Based on observation and interview, the facility failed to maintain two of five exit doors as to not require special knowledge or effort to unlock the door from inside the building. This deficient practice affected all residents of the facility. The census was 36.</p> <p>1. Observations on 3/18/10 between 9:45 A.M. and 2:30 P.M. and 3/27/10 between 1:45 P.M. and 7:00 P.M., showed the facility had two exits that staff locked and unlocked with a key. The staff, in charge, had keys to those doors. Observation of the south exit (main entrance) door, showed a key locked door, foyer, and another key locked door that staff had to unlock for residents, staff and visitors to enter or exit the facility. The north exit door also required staff to use a key to lock and unlock the door for residents, staff and visitors to enter or exit the building.</p> <p>2. During an interview on 3/25/10 at 2:20 P.M., the Director of Nursing (DON) said the facility had</p>	A2229 A229 05-11- 2010	<p style="text-align: right;">5-21-10</p> <p>1 (A) Accessible exits to front entries will be changed to internal locks that can be opened without a key. All other existing locks/exits can be opened with push bars.</p> <p>7 (A) Each floor of a facility has at least 2 unobstructed exits remote from each other.</p>	
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Missouri Department of Health and Senior Services

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE Owner (X6) DATE 5-12-10

STATE FORM 6898 EED611 If continuation sheet 1 of 21

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A2229 Continued From page 1

three exit doors with push bars, and two exit doors that required a key to unlock when going in and out of the facility.

3. During an interview on 3/25/10 at 1:36 P.M., Social Worker K said he/she visited residents at the facility for the past two years. Facility staff always have to use a key to let him/her in and out of the building.

4. During an interview on 3/25/10 at 9:50 A.M., Certified Medication Technician (CMT) B said the facility was completely locked at all times. Staff had to use a key to unlock all exit doors in order to get in and out of the facility. The CMT thought the doors had been locked with a key for the past ten years.

5. During an interview on 3/27/10 at 2:25 P.M., Resident #6 said he/she came and went when he/she wanted. Staff had to unlock the door and let him/her out whenever he/she wanted. Some residents were on "lock down". Those residents' guardians would not allow the residents out of the building without staff supervision.

A2229

A4401 19 CSR 30-66 043(2)

(2) A person shall be designated to be administrator who is currently licensed as a nursing home administrator under Chapter 344, RSMo II

This regulation is not met as evidenced by Based on observation, interview and record review, the facility failed to provide a licensed nursing home administrator who was responsible for the management and operations of the facility. The census was 36

A4401
05-11-
2010

Licensed Nursing Home Administrator start Date 05-03-2010

PRINTED: 04/13/2010 10:08 AM

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A4401	<p>Continued From page 2</p> <p>1 Observations on 3/18/10, 3/27/10 and 4/9/10, showed no administrator at the facility.</p> <p>2. During an interview on 3/24/10 at 3:22 P.M., the facility Owner said the facility did not have a current administrator. The former administrator resigned on 3/10/10. The Owner contacted the association for nursing home administrators and posted a job listing. He is reviewing resumes and planned to start interviewing "next week". The owner had not applied for an emergency administrator license.</p> <p>3. During an interview on 3/25/10 at 8:38 A.M., a representative from the Board of Nursing Home Administrators said he/she received a faxed letter from the facility on 3/17/10 stating their administrator resigned 3/10/10. The letter stated the Director of Nursing (DON) would be the interim administrator. The facility did not apply for a temporary emergency license and the ten day window to apply had passed. The facility had to have a licensed administrator. The Board denied the owner a license in February 2010 because he was not qualified as an administrator.</p> <p>4 Review of a faxed letter to the Board of Nursing Home Administrators, dated 3/17/10, showed the administrator was no longer employed at the facility. The administrator's last day was 3/10/10. The facility's Licensed Practical Nurse (LPN) would serve as interim administrator until they hired a new administrator.</p> <p>5 During an interview on 3/25/10 at 9:30 A.M., the DON said there was not a current administrator at the facility. The DON said she was not a licensed nursing home administrator and was not aware the owner told the Board of Nursing Home Administrators she would be the</p>	A4401		
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A4401	Continued From page 3 interim administrator. 6. During an interview on 4/12/10 at 10:22 A.M., the Owner said he did not have an Interim administrator. He posted the position on a website and would be conducting interviews that week. A4420 19 CSR 30-86 .043(25) (25) All residents shall be physically and mentally capable of negotiating a normal path to safety unassisted or with the use of assistive devices. I/II This regulation is not met as evidenced by: Class II Based on observation, interview and record review, the facility failed to ensure all residents mentally and physically could evacuate the building in case of an emergency. The facility failed to ensure one of seven sampled residents was able to negotiate a path to safety. (Resident #1) The census was 36. Review of Resident #1's physician order sheets, dated March 2010, showed the resident moved to the facility on 4/2/07. The physician orders showed the resident diagnosed with chronic paranoia, schizophrenia with exacerbation, dementia, chronic renal insufficiency, and severe psychiatric illness. Review of the resident's social progress note, dated 2/24/10, showed the resident alert and oriented to person and place. Staff and other residents provided the resident with directions to the smoking area and grooming. Coaching from staff was required at times.	4428 05-24-2010	A pathway to safety for the residents of KF Jammer Manor West will be implemented effective by May 24, 2010 via instructions to staff and residents as following: (1) All independent ambulatory residents will be instructed on a pathway to safety to use the closest exit doors in the areas where they are located at the time of emergency evacuation. (2) All residents that need guidance (cuing) will be instructed and assisted with a pathway to safety by all staff (nursing, housekeeping, and dietary) whenever emergency evacuation is imminent. (05-24-2010) (3) Pathways of safety will be monitored by DON/Administrator, with a routine practice run every two weeks on Thursdays. (05-24-2010) (a) A form will be created for a sign in roster for all residents and staff on duty to sign as a record of the practice run. The signed forms will be kept at the nursing station. (b) A list of residents' names will accompany all emergency exits evacuations.	

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A4437	Continued From page 5 twenty-four (24) hours a day. For residents departing the premises on voluntary leave, the facility shall have, at a minimum, a procedure to inquire of the resident or resident's guardian of the resident's departure, of the resident's estimated length of absence from the facility, and of the resident's whereabouts while on voluntary leave. III This regulation is not met as evidenced by: Class I Based on observation, interview, and record review, the facility failed to provide protective oversight for one resident who sustained facial bruising on 3/21/10. The facility did not investigate, obtain statements from residents and staff, or provide monitoring to protect the resident from further injuries (Resident #1). The facility also failed to provide protective oversight for two residents (Resident #3 and #4) who were continually called racial and degrading names, spit on, and thrown water on by another resident (Resident #2). The facility failed to investigate and put measures into place to protect one resident who alleged an unknown resident raped the resident and alleged a sexual relationship with an employee (Resident #3). The facility also failed to investigate and put measures into place to protect residents after receiving an allegation of a sexual act between an employee and a resident (Resident #5). The census was 36. 1. Review of Resident #1's physician order sheets, dated March 2010, showed the resident moved to the facility on 4/2/07. The physician orders showed the resident diagnosed with chronic paranoia, schizophrenia with exacerbation, dementia, chronic renal insufficiency, and severe psychiatric illness. The	A4437 05-11- 2010	(1) Resident #2 will be monitored for aggressive behavior and when necessary taken out of harms way from other residents for continued safety compliance by nursing staff each shift. (2) Resident #3 and #4 was discharged 04-08-2010. (3) All above plans will be conveyed to all staff via shift report and continued in services will be done every 2 weeks on payday by RN Consultant/Administrator.	

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A4437 Continued From page 6

physician orders showed Physician F as the resident's primary care physician.

Review of the resident's nurses' notes, dated 3/21/10 at 4:00 P.M., showed the resident came out of the dining room with the left side of his/her face swollen and eye slightly discolored. The resident was unable to tell staff what happened. Staff called the resident's guardian and informed the guardian of the "resident's left eye being swollen and was hit by unknown - possibly by another resident who the resident attempted to take a soda from, but story cannot be confirmed." Further review of the resident's nurses' notes showed no assessment or monitoring of the resident after 3/21/10.

During an interview on 4/9/10 at 11:45 A.M. Cook D said the resident came into the dining room at noon on 3/21/10 for lunch. The resident's face was bruised and swollen. Both eyes were puffy and blue; one eye looked worse than the other eye. His/her face was also puffy and blue. Someone (he/she could not remember who) told the cook the resident fell earlier in the morning. The cook thought it looked like "an awful lot of bruising and swelling" for a fall. He/she did not say anything to other staff because he/she assumed "everyone" already knew. The cook did not see or hear any altercations in the dining room on 3/21/10.

During an interview on 3/31/10 at 10:15 A.M., Certified Medication Technician (CMT) B said he/she went to the dining room on 3/21/10 around 4:00 or 4:30 P.M. to get the resident from dinner. The resident had a swollen left jaw. The resident did not know what happened. None of the other residents in the dining room knew, or said, what happened to the resident. The CMT thought

A4437
05-24-
2010

- (1) Nursing staff will be updated via each shift on all residents' condition.
- (2) Safety in service has been completed with all staff on May 13-2012.
- (3) All staff has been instructed on reporting to appropriate sources (DON, Administrator, Family, SSW, Owner, Guardian, Physician, and hotline if appropriate) and all staff has been instructed via in service by Administrator on documentation of residents' condition especially when there is a problem with residents' safety on May 05, 2010.
- (4) Resident #3 and #4 are discharged from the facility on 04-08-2010.

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A4437	<p>Continued From page 7</p> <p>maybe the resident tried to take someone's soda and maybe the other resident hit the resident, but that was "just a guess". No one told the CMT the story about the soda.</p> <p>Observation on 3/27/10 at 1:55 P.M., showed the resident with dark purple and black bruising surrounding both eyes and down the left side of the face. The resident walked with a shuffled gait.</p> <p>During an interview on 3/27/10 at 1:55 P.M., the resident was unable, or unwilling, to say what caused the bruising. The resident was also unable to say his/her name.</p> <p>During an interview on 3/27/10 at 1:56 P.M., Level One Medication Aide (L1MA) C said the resident got into an altercations with another resident about a week ago, but the L1MA did not know any details.</p> <p>During an interview on 3/27/10 at 2:50 P.M., the Director of Nursing (DON) said she heard the residents were eating in the dining room on 3/21/10 and Resident #1 tried to take one of the other resident's soda. Resident #1 swung at the other resident and the other resident hit Resident #1. The DON then said the "soda story is a rumor". She did not really know what happened to the resident. She did not investigate or interview any residents or staff regarding the resident's facial bruising. CMT B placed ice on the resident's face that day. The DON called the resident's guardian and physician on 3/22/10 and informed both of the bruising. The DON guessed she forgot to document her call to the physician. She left a message for the physician, but never received a call back.</p>	<p>A4437</p> <p>05-24-2010</p> <p>05-11-2010</p> <p>05-13-2010</p> <p>05-15-2010</p>	<p>Historically expect a decrease of any incident/allegation/abuse that may occur with appropriate reporting and documentation to follow. If necessary hotline will be implemented and disciplinary action to appropriate personnel. Will continue residents' protective oversight.</p> <p>In services will be conducted by RN Consultant/Administrator/DON every 2 weeks on payday. In services done as following:</p> <p>(1) 05-05-2010 Appropriate reporting and documentation</p> <p>(2) 05-13-2010 on Patient safety and fire drills (fire drill done after in service)</p> <p>(3) Future in services will be done on (a) personal care/bathing/grooming, patients rights, hippa compliance;</p> <p>(b) Dementia (possibly provided by Alzheimer Foundation); (c) Incidence/slash/injuries</p>