STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265369	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crystal Oaks	1500 Calvary Church Road Festus, MO 63028

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a bed hold policy upon transfer to the hospital for two residents (Residents #7 and #79) out of five sampled residents and failed to notify the resident and/or the resident's representative in writing of a transfer or discharge to the hospital for one resident (Resident #79) out of five sampled residents. The facility also failed to complete a discharge summary that included a recapitulation of stay, describing the resident's course of treatment while residing in the facility, for one resident (Resident #136) out of two closed records reviewed. The facility's census was 120. The facility did not provide a policy. 1. Review of Resident #7's medical record showed: - admitted on [DATE]; - Transferred to the hospital on [DATE] and returned to the facility on [DATE]; - Transferred to the hospital on [DATE] and returned to the facility on [DATE]; - Transferred to the hospital on [DATE] and returned to the facility on [DATE]; - No documentation that a copy of the bed hold policy was provided to the resident and/or the resident's representative. 2. Review of Resident #79's medical record showed: - admitted on [DATE]; - Transferred to the hospital on [DATE] and returned to the facility on [DATE]; - Transferred to the hospital on [DATE] and returned to the facility on [DATE]; - No documentation that written notification was provided to the resident and/or the resident's representative of the transfer. 3. Review of Resident #136's medical record showed: - admitted on [DATE]; (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- discharged on 09/08/25; - An order to discharge to another facility with hospice evaluation, dated 09/08/25; - A Summary of Episode with no assessment, no encounters, no goals, no functional status, no health concerns, no medical equipment, no medications, no plan of treatment, no procedures, no reasons for referral, and no diagnostic results documented; - No discharge summary or progress note regarding the resident's discharge; - No recapitulation of stay. During an interview on 12/04/25 at 1:30 P.M., the Director of Nursing (DON) said when they discharge a resident, they send a face sheet and a medication list to the facility they're transferring to. This resident discharged to another facility per the resident's choice. She believes they can pull the information from different sources, but they don't have it all together in one place, as is being requested. She is not familiar with the recapitulation of stay, but she is able to provide a Summary of Episode. She would expect there to be a progress note in the chart when a resident discharges. During an interview on 12/04/25 at 2:30 P.M., the Administrator and DON said they would expect a recapitulation of stay to be completed when a resident is discharged and a written notification of transfer and a copy of the bed hold policy to be provided to the resident and/or the resident's representative when transferred out of the facility.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to maintain infection control practices to prevent the development and transmission of infection during wound care for one resident (Resident #27) and urinary catheter (a flexible tube that is placed to drain urine from bladder) care for one resident (Resident #44) out of three sampled residents. The facility census was 120.Review of the facility's Handwashing/Hand Hygiene policy, revised October 2023, showed:- The facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections;- Hand hygiene is indicated immediately before touching a resident, before performing an aseptic (to keep free from germs) task, such as handling an invasive medical device, after contact with blood, body fluids or contaminated surface;- Hand hygiene is indicated after touching a resident, a resident's environment, before moving from work on a soiled body site to a clean body site on the same resident, and immediately after glove removal;- Use an alcohol-based hand rub containing at least 60 percent alcohol for most clinical situations;- Wash hands with soap and water when hands are visibly soiled and after contact with a resident with infectious diarrhea;- Single-use disposable gloves should be used before an aseptic procedure, when anticipating contact with blood or body fluids, and when in contact with a resident or equipment or environment of a resident on contact precautions;- The use of gloves does not replace hand washing/hygiene. 1. Observation of wound care for Resident #27 on 12/04/25 at 10:10 A.M., showed:- Licensed Practical Nurse (LPN) A washed hands, placed a towel barrier on the bedside table, and donned a gown and gloves;- LPN A obtained a plain packing strip (type of dressing) container, alginate (highly absorbent wound dressing), small amount of gentamicin (antibiotic ointment) and barrier cream in separate cups, and scissors from the treatment cart, then placed the supplies on the covered bedside table;- LPN A placed a clean towel under the resident and positioned on his/her side;- LPN removed gloves, sanitized hands and donned clean gloves;- LPN A obtained cleanser from the table, sprayed onto the wound, set back on the table, cleaned the wound with a gauze pad and removed gloves;- Without sanitizing, LPN A donned clean gloves, placed barrier cream around the wound with a cotton swab and removed gloves; - Without sanitizing, LPN A donned clean gloves and placed gentamicin in the wound with a cotton swab;- With the same gloves, LPN A removed packing from the container and placed into the wound with a cotton swab;- LPN A removed gloves, sanitized hands, and donned clean gloves;- LPN A placed alginate with a gloved finger onto the wound and applied dressing;- With the same gloves, LPN A removed the towel from under the resident, assisted the resident with his/her pants, and repositioned;- LPN A removed gloves, carried supplies inside of the towel to the treatment cart, removed gown, and washed hands;- LPN A, without cleaning the shared containers, placed the alginate container and the wound cleanser in the cart. During an interview at 10:30 A.M., LPN A said the containers should have been cleaned before placing back into the cart. 2. Observation of urinary catheter (a flexible tube inserted into the bladder to drain urine) care for Resident #44 on 12/04/25 at 10:35 A.M., showed:- Certified Nurse Aide (CNA) B and CNA C washed hands and donned gowns and gloves;- CNA B placed a towel on the bed as a barrier, then placed the washcloths and new bags on the barrier;- CNA B and CNA C pulled the bed away from the wall and pulled the cover from the resident;- CNA B lowered the bed and removed the resident's brief; - CNA B cleaned both sides of the groin area with a clean wipe each time, provided by CNA C; - With the same gloves, CNA B cleaned around the urinary catheter insertion site and down the catheter several inches with a clean cloth;- With the same gloves, CNA B removed the resident's protective boots, placed the urinary bag onto the bed, and assisted the resident to his/her left side;- With the same gloves, CNA B cleaned the buttock area with a clean washcloth and rolled the resident to his/her right side;- CNA C placed a clean brief under the resident, rolled the resident onto his/her back, attached the brief, and placed the protective boots back on the resident;- CNA C removed gloves, sanitized hands, donned clean gloves, placed the bed against the wall, locked the wheels in place, and placed the call light near the resident;- CNA B removed gloves, sanitized hands, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	donned clean gloves, drained the urine from the urinary collection bag into a graduated cylinder (a container with a scale used to measure liquid), and emptied in the bathroom;- With the same gloves, CNA B adjusted the resident's pillow and blanket and moved the bedside table closer to the resident;- CNA B and CNA C removed gowns, gloves, and sanitized hands before leaving the room. During an interview on 12/04/25 at 10:54 A.M., CNA B said gloves should have been removed and hands sanitized after moving the bed, touching the blanket, and prior to beginning catheter care. Hands should have been sanitized and new gloves placed after the catheter bag was emptied and before touching the resident's pillow and blanket. During an interview on 12/04/25 at 2:30 P.M., the Administrator and Director of Nursing said they would expect staff to use proper hand hygiene when performing wound and urinary catheter care and items/containers should be cleaned after being handled with dirty gloves prior to placing back into the treatment cart.