STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265823	A. Building B. Wing	12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestwood Health Care Center, LLC	11400 Mehl Avenue Florissant, MO 63033

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34926 This deficiency is uncorrected. Please see the Statement of Deficiencies dated 03/19/24 for previous examples. Based on observation, interview and record review, the facility failed to ensure one of 11 sampled residents was free from physical abuse (Resident #101). The resident is legally blind and hard of hearing. On 4/28/24 at approximately 7:30 P.M., the resident asked Dietary Aide (DA) A for coffee, and DA A said the resident could not have coffee because the kitchen was almost closed. During the conversation, the resident put his/her hands up while talking. DA A grabbed the resident's wrists and then grabbed the resident's throat. Floor Technician (FT) B intervened and separated DA A and Resident #101. Certified Nurse's Aide (CNA) C was in the doorway to the smoking room and yelled out Code Green (behavioral emergency to notify additional staff). Certified Medication Technician (CMT) D heard the Code Green and brought the resident to his/her room. After the incident, DA A went to the smoking room with other residents. DA A remained in the facility and clocked out at his/her regular time at 8:00 P.M. The facility staff failed to ensure the safety of the other residents on the evening of the incident. The census was 146. The administrator was informed on 5/3/24 of an Immediate Jeopardy (IJ), which began on 4/28/24. The IJ was removed on 5/3/24 as confirmed by surveyor on-site verification. Review of the facility's Abuse and Neglect Policy, dated revised 1/5/23, showed: -Purpose: To outline procedures for reporting and investigating complaints of abuse, neglect, and misuse of funds/property, and to define terms of types of abuse/neglect and misappropriation of funds and property. To ensure immediate reporting of all abuse allegations to the Administrator or designee and the Director of Nursing or designee and outside persons or agencies. To establish actions related to the alleged perpetrator and to ensure investigation and assessment of all residents involved is completed; -Physical Abuse - Purposefully beating, striking, wounding, or injuring any resident or any manner whatsoever mistreating or maltreating a resident in a brutal or inhumane manner. Physical abuse includes handling a resident with any more force than is reasonable for a resident's proper control, treatment or management. Physical abuse also includes, but is not limited to, hitting, slapping, punching, biting, and kicking. Physical abuse also includes corporal punishment, which is physical punishment used as a means to correct or control behavior; (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265823	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/08/2023
NAME OF PROVIDER OR SUPPLIER Crestwood Health Care Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 11400 Mehl Avenue Florissant, MO 63033	

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Mistreatment, neglect, or abuse of residents is prohibited by this Facility. This includes physical abuse, sexual abuse, verbal abuse, mental abuse and involuntary seclusion; -This Facility is committed to protecting our residents from abuse by anyone including, but not limited to, Facility staff, other residents, consultants, volunteers, and staff from other agencies providing services to the individual, family members or legal guardians, friends, or any other individuals; -This Facility does not condone resident abuse by anyone, including employees, physicians, consultants, volunteers, and staff of other agencies serving the resident, family members, legal guardians, sponsors, other residents, friends, or other individuals. It is the responsibility of employees, Facility consultants, attending physicians, family members, and visitors etc., to promptly report any incident or suspected incident of abuse/neglect/misappropriation of funds to Facility management immediately. If such incidents occur after hours the Administrator or designee and Director of Nursing or designee will be notified at home or by cell phone and informed of any such incident; -Employees are trained through orientation and ongoing training on issues related to abuse prohibition practices, such as: --Dealing with aggressive residents; --Reporting allegations with fear of reprisal; --Recognizing signs of burnout, frustrations or stress that may lead to abuse; --The definition that constitutes abuse, neglect and misappropriation of resident property; -During orientation of new employees, the facility will cover at least the following topics: --Sensitivity to resident rights and resident needs and what constitutes physical, sexual, verbal and mental abuse; --Staff obligations to prevent and report abuse; --How to assess, prevent and manage aggressive, violent, and/or catastrophic reactions of residents in a way that protects both residents and staff; --How to recognize and deal with burnout, frustration and stress that may lead to inappropriate responses or abusive reactions to residents; --Reporting abuse and their obligations under law when receiving an allegation of abuse; -On an annual basis, staff will receive a review of the above topics; (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Upon learning of the report of abuse or neglect, the Administrator shall initiate an incident investigation. The nursing staff is additionally responsible for reporting and investigating the appearance of bruises, lacerations, or other abnormalities as they occur. Upon report of such occurrences, the nursing supervisor is responsible for assessing the resident, reviewing the documentation, and reporting to the Administrator or designee; -The Facility will take steps to prevent mistreatment while the investigation is underway: -Employees of this Facility who have been accused of mistreatment will be immediately removed from contact with any residents and must leave the Facility pending the results of the investigation and review by the Administrator; -Employees accused of possible mistreatment shall not complete the shift and will immediately be sent home. Review of Resident #101's admission record showed the resident admitted to the facility on [DATE] with diagnoses that included bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), hearing loss, legal blindness and dyskinesia (involuntary, erratic, writhing movements of the face, arms, legs or trunk). Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/29/24, showed: -Cognitively intact; -Ability to hear (with hearing aid or hearing appliances if normally used): Adequate. No difficulty in normal conversation, social interaction, listening to TV; -Hearing Aid or other hearing appliance used: No; -Speech Clarity: Unclear Speech: Slurred or mumbled words; -Ability to express ideas and wants, consider both verbal and nonverbal expression: Usually understood. Difficulty communicating some words or finishing thoughts but is able if prompted or given time; -Ability to understand others, understanding verbal content, however able (with hearing aid or device if used): Understands. Clear comprehension; -Ability to see in adequate light: Moderately impaired. Limited Vision, not able to see newspaper headlines but scan identify objects; -Corrective Lenses: No; -How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy? Never; -Psychosis: None; (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Behavioral Symptoms: --Physical behavioral symptoms directed towards others: Behavior not exhibited; --Verbal behavioral symptoms directed towards others: Behavior not exhibited; --Other behavioral symptoms not directed toward others: Behavior not exhibited; -Rejection of Care: Behavior not exhibited; -Wandering: Behavior not exhibited. Review of the resident's current care plan, showed: -Focus: At risk for behavior problems related to schizophrenia and bipolar disorder; -Goal: Ensure protective oversight is provided through next review; -Interventions: Anticipate and meet the resident's needs, caregivers to provide opportunity for positive interaction, attention, stop and talk with him/her as passing by, if reasonable discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable; -Focus: At risk for a deficit in communication problem related to dx of legal blindness and hearing loss. Has decreased sensory perception. Is best at communicating face to face and has a Russian ethnicity. He/She uses hearing aides and glasses; -Goal: Will be able to make basic needs known on a daily basis through the review date; -Interventions: Be conscious of resident position when in groups, activities, dining room to promote proper communication with others; Allow adequate time to respond, Repeat as necessary, Do not rush, Request clarification from the resident to ensure understanding, Face when speaking, make eye contact, Turn off TV/radio to reduce environmental noise, Ask yes/no questions if appropriate, Use simple, brief, consistent words/cues, Use alternative communication tools as needed; Encourage resident to continue stating thoughts even if resident is having difficulty. Focus on a word or phrase that makes sense, or responds to the feeling resident is trying to express. Review of DA A's Abuse and Neglect Policy Acknowledgment (located in his/her personnel file), showed: -The statement: I am acknowledging that I have received, read, understand and had the opportunity to ask questions concerning the Abuse and Neglect policy; -Signed by DA A; -Dated: 4/23/24, five days prior to the incident. Review of the video evidence, dated 4/28/24, showed: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-The resident was noted in the dining room walking towards the kitchen area and DA A walked to stand in front of Resident #101; -At time stamp 00:09, DA A grabbed for the resident using his/her right hand, the resident grabbed DA A's right hand with his/her left hand; -At time stamp 00:11, DA A grabbed towards resident's right shoulder/neck area with his/her left hand, then also moved his/her right hand to the resident's throat with the resident still trying to hold the right hand back; -At time stamp 00:15, the resident was able to step back and push DA A's hands off his throat; -At time stamp 00:16, FT B stepped in between DA A and the resident. FT B did not remove the resident from the situation or request DA A to move away from the resident; -At time stamp 00:25, FT B turned his back on DA A and the resident and started walking away; -At time stamp 00:26, CMT D was approaching at this time. DA A started stepping forwards again towards the resident; -At time stamp 00:28, CMT D put his/her arm out and blocked DA A from moving towards the resident and motioned for him to walk away and started speaking with the resident; -At time stamp 00:32, DA A was no longer visible in the video. FT B was walking towards the direction of DA A; -At time stamp 00:34, FT B stood between the resident and the direction DA A walked; -At time stamp 00:49, CMT D was still standing in the same place in the dining room talking with the resident, and the video ended. Review of DA A's Individual Employee Time Cards showed he/she clocked out at 8:00 P.M. Review of the resident's electronic progress notes for the months of April 2024 and May 2024, showed: -4/28/24 at 8:00 P.M.: Resident alert and up ad lib. Resident continues monitoring for meal consumption. Resident in dining room for dinner. Consumed 100% dinner. Staff will continue to monitor for protective oversight; -4/29/24 at 7:18 A.M.: Late Entry: Resident stated on 4/28/24 staff member put (his/her) hands around my neck and choked me. Head to toe skin assessment. No apparent injury noted. No bruising or discoloration noted. Placed call to the resident's physician and guardian and made them aware of incident. Administrator, Director of Nurses (DON) and Social Service aware. No complaints of pain or discomfort at the present time. -Skin assessment on 4/29/24 at 10:25 A.M.: Skin warm and dry, skin color within normal limits and turgor is normal; (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-4/29/24 at 6:20 P.M.: Continues on observation. No acute distress noted. Denies pain or discomfort; -4/30/24 at 7:22 A.M.: Continues on observation. No acute distress noted. Denies pain or discomfort; -4/30/24 at 8:53 A.M.: Administrator spoke with the guardian regarding the staff to resident incident that occurred on 4/28/24. The guardian was happy to hear how the facility handled the situation. The guardian was very understanding and empathetic; -4/30/24 at 9:06 A.M.: Law enforcement was notified of the staff to resident incident that occurred on 4/28/24; -4/30/24 at 9:53 A.M.: Resident's guardian notified Social Services Director (SSD) of an assault on resident by staff member. Allegation was investigated and law enforcement was called in. SSD spoke with resident on how he/she was feeling; resident appeared to be doing fine and stated he/she was doing ok. SSD will follow up with resident over the next 72 hours; -4/30/24 at 12:44 P.M.: Resident remains on close monitoring at this time. Resident is up ad lib to meals and group. No change in level of functioning. Resident able to voice feelings and concerns with staff. Resident denies pain or discomfort at this time. Neurologic (neuro, refers to a person's nervous system function including mental status, coordination, ability to walk, and how well the muscles, sensory systems, and deep tendon reflexes) checks (an assessment tool to determine a patient's neurologic function) remains in place. Staff will continue to monitor for protective oversight; -4/30/24 at 11:25 P.M.: Resident alert and up ad lib. Resident continues monitoring for altercation. Neuro checks completed and within normal limits for resident's baseline. Resident not noted to have any increased agitation or aggression this shift. Denies pain. Staff will continue to monitor for protective oversight; Review of the facility's Administrator/Registered Nurse (RN) Investigation dated 4/30/24, showed: -Date of incident: 4/29/24; -Type of incident: Alleged abuse; -Person(s) involved in the incident: --Resident #101; --DA A; -Witnesses: --FT B; --CNA C; (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	--CMT D; -Statements received from witnesses: Yes; -Statement received from affected person(s): Yes; -Supportive intervention documentation attached: Yes; -Guardian notified of the incident: Yes; -By whom: Social worker; -Date and time notified: 4/29/24 at 2:00 P.M.; -Physician notified of incident: Yes; -By who: RCC; -Date and time: 4/29/24 at 2:30 P.M.; -Documentation of incident completed: Yes; -By who: RCC; -Disciplinary action required: Yes; -Narrative Note: the resident went to the kitchen door attempting to get coffee and was unsuccessful as DA A sent him/her away from the door. The resident walked to the back of the dining room then came back up to the dietary door where the alleged abuser was standing. The resident walked up asking DA A for coffee again when DA A started to take a stance with the resident, causing the resident to move his/her hands towards DA A. DA A then attempted to grab the resident in the neck area. Another resident was standing there and he/she was able to get the resident to move back from DA A. CMT D walked into the dining room and noticed that DA A was holding the resident's arms. CMT D then rushed up to see what was going on and officially removed the resident away from DA A. CMT D began to question DA A and was told that the resident wanted coffee and was told that there was none left, DA A added that the resident then came back trying to gain entrance into the kitchen so DA A was attempting to stop the resident. CMT D did not see DA A's hands around the resident's neck. CMT D simply thought it was a misunderstanding. CMT D also took the time to educate DA A, who is a new worker and had been working in the facility for maybe a week. The resident's sibling actually called the Social Worker on 4/29/24, to ensure that the facility knew what had occurred. We then started a full investigation. Head to toe assessment done on the resident showed no injuries; (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Conclusion/Outcome of the Investigation: All other residents were interviewed to ensure they are safe and that they felt safe. Abuse and neglect in-service also began again, in light of what happened. We also interviewed staff that may have seen this event and carried out disciplinary actions. I went to assess the resident again for any physical or mental wound. He/She appears to be ok. None noted at this time. The resident is VERY hard of hearing which poses a problem as well. If he/she can't hear to understand and in this case the staff was new, it can cause an issue for the resident and staff; -Care plan changes and interventions: Facility will follow up on the resident's hearing aides to see why he/she doesn't have them and get them. Will speak to his/her family as well; -Employee witness statement obtained; -The care plan must reflect new interventions as a result of this behavior emergency crisis: See about why he/she is not wearing hearing aids. -Signed by the Administrator and DON, dated 5/1/24. Review of DA A's Employee/Witness statement, dated 4/29/24, showed: -Resident 101 walked up to DA A in the kitchen door asking for coffee. He/She told the resident it was empty. In that moment, the resident demanded DA A to move out of the way. When he/she didn't move, the resident grabbed his/her arm with strength force. DA A grabbed the resident's neck as protecting himself/herself. DA A heard a co-worker call Code Green (a call for emergency assistance related to a physical encounter in progress), but he/she did not see the people coming to help. But the situation did calm down and they took the resident to a different area as he/she went to the smoking room. Review of CMT D's Employee/Witness Statement, dated 4/29/24, showed: -CMT D was on his/her way to the dining room to get some ice to pass medications. While there a resident called Code Green. Upon arrival, he/she saw the staff holding the resident by the arm. CMT D rushed over to stop then and asked the staff what happened. DA A told CMT D that the resident wanted some more coffee. DA A told the resident that there was no more coffee but the resident did not believe DA A said the resident tried to get into the kitchen. CMT D took the resident to the 600 hall (a locked unit) to cool off because the resident was angry. Review of FT B's Employee/Witness Statement, dated 4/30/24, showed: -All FT B saw was DA A and the resident having a problem. the resident was trying to get in the back of the kitchen because he/she was upset because there wasn't any more coffee. So, DA A was standing there and he/she grabbed the resident's arm. Review of CNA C's Employee/Witness Statement, dated 4/30/24, showed: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-On Sunday, May 28 (DHSS verified with writer this was supposed to read April, not May), while smoking the residents, he/she heard yelling and looked up. CNA C saw DA A had a hold of the resident, so he/she yelled a Code Green. A couple of other staff came to intervene and separated the two. He/she did not hear what started the incident because he/she was busy smoking population. Review of the resident's record, showed: -5/1/24 at 11:21 A.M.: Late Entry: Psychosocial Post-Incident Impact Note: the resident was involved in an incident as the victim. --the resident was asked do you feel safe? Yes --the resident was asked do you have any after effects from incident? No --the resident was asked do you have any other needs or items that you would like addressed? No; -5/1/24 at 1:54 P.M.: Remains on observation. -5/1/24 at 10:15 P.M.: Last day observation no concerns were voiced; -5/2/24 at 10:52 P.M.: Staff will continue to monitor for protective oversight. During an interview on 5/2/24 at 1:45 P.M., the resident said: -He/She is very hard of hearing; -He/She was legally blind and could not read a written question; -DA A grabbed him/her around the throat for asking for coffee; -He/She was not hurt at the time, just surprised; -He/She knows one thing, he/she will never ask for coffee again if this is what is going to happen; -He/She feels safe in the facility since DA A no longer works at the facility. During an interview on 5/2/24 at 2:35 P.M., DA A said: -One of the residents walked up to him/her by the kitchen door requesting coffee; -DA A told the resident there was no more coffee; -The resident told DA A to move out of his/her way. The resident was going to try to go in the kitchen; -DA A told the resident no; -The resident raised his/her arms and then DA A raised his/her arms; (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-DA A then grabbed the resident's neck and was in defense mode; -He/She had not been properly trained. He/She had orientation and started the next day in the kitchen; -In orientation, he/she learned if a resident attacks you, you can defend yourself; -They didn't teach to ask for help or verbally de-escalate. They taught us nothing and then he/she started the next day; -He/She was told to tell residents who ask that there was no more coffee; -The kitchen was being closed as it was almost 8:00 P.M.; -DA A doesn't make coffee and was told not to by the Supervisor; -He/She said the residents get coffee at breakfast, lunch and dinner; -The resident showed aggressiveness by raising his/her arms; -He/She resident grabbed DA A's arm and he/she was showing strength; -DA A showed his/her defense move and grabbed the resident's neck; -When asked if they discussed abuse -verbal and physical at orientation, he/she said they didn't get into any details; -If he/she had proper training he/she wouldn't be going through this; -He/She was never told the proper protocol; -When asked if he/she would consider his/her actions physically abusive, he/she said you can't skip to that part when asking about his/her actions. This was a reaction to the resident showing his/her physical strength. During an interview on 5/2/24 at 3:23 P.M., CMT D said: -He/She was on the CMT cart and walking to the kitchen for ice when he/she heard someone yell out Code Green; -CMT D noted DA A holding the resident by the throat; -CMT D ran over and told DA A You can't hold (him/her) like that; -The resident was a little angry and upset, so CMT D took him/her onto 600 unit (locked unit) to cool off; -The resident said he/she asked DA A for coffee and DA A refused to give him/her any coffee; (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-DA A told CMT D the resident asked for coffee, there wasn't any left and he/she told this to the resident. The resident still kept trying to get past DA A into the kitchen. DA A said he/she grabbed the resident in self-defense; -CMT D did not report the incident to Administration because he/she saw Nurse E in the dining room performing blood sugar checks when he/she entered the dining room; -CMT D assumed Nurse E would write up the incident and notify Administration when Nurse E finished blood sugar checks. During an interview on 5/2/24 at 3:34 P.M., CNA C said: -He/She stood in the doorway of the smoking room, when he/she heard a commotion coming from the dining room. He/She looked up and saw DA A with his/her hands on the resident; -He/She could not tell where DA A had a hold of the resident; -He/She yelled a Code Green; -He/She saw two staff members intervene. He/She did not intervene because he/she could not leave the residents unattended while smoking; -DA A left the dining room after staff intervened and entered the smoking room with smoking residents; -CMT D took the resident away from the dining room; -He/She did not talk with DA A when he/she entered the smoking room and did not attempt to stop him/her from entering the smoking room; -He/She does not know how long DA A stayed in the smoking room with the residents; -He/She did not report the incident because he/she thought the staff who intervened would tell the nurse and report it. During an interview on 5/2/24 at 3:50 P.M., FT B said: -He/She stood in the dining room and witnessed the altercation; -The resident was trying to get coffee and go past DA A into the kitchen; -The resident grabbed DA A's arm and DA A had his/her hands on the resident's throat when FT B went to intervene; -FT B got between them and separated them; -CMT D came in then to assist, but he/she did not see the incident; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestwood Health Care Center, LLC	11400 Mehl Avenue Florissant, MO 63033

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-CNA C yelled out a Code Green from the smoking room; -FT B did not have a walkie talkie on him/her to make a Code Green announcement; -CMT D took the resident to his/her room and DA A went into the smoking room; -There were residents in the smoking room; -He/She did not stop DA A from entering the smoking room; -FT B did not ask DA A why he/she grabbed the resident by the throat and DA A did not offer a reason; -It was not acceptable for staff to grab a resident by the throat; -He/She did not report the incident because someone else called the Code Green, so he/she wasn't aware that he/she needed to report it; -He/She assumed the person who yelled Code Green would report it and it would be on video and they would question him/her about it; -He/She received abuse and neglect in-servicing earlier in April. During an interview on 5/3/24 at 10:39 A.M., RN E said: -He/She was in the dining room performing blood sugar levels at the time of the incident; -He/She was not sure what time this occurred; -He/She did not witness the incident; -The dining room was loud and he/she did not hear the incident or the staff yell out Code Green; -No one reported the incident to him/her; -He/She did not assess the resident after the incident; -To his/her knowledge, the other nurse on duty, Nurse F, was not notified and did not assess the resident either; -Staff should have notified him/her or Nurse F of the incident; -If he/she was notified, he/she would have pulled DA A off the floor immediately and sent him/her home; -He/She would not have allowed DA A to enter the smoking room with other residents due to the potential for additional resident harm; (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-He/She would have performed a head to toe assessment on the resident had he/she been notified; -He/She would have then notified administration, the resident's physician and family; -He/She did not work the next day and did not know about the incident until the DON called on 4/29/24 to ask if he/she was aware of the situation and what actions were taken, if any. During an interview on 5/3/24 at 10:48 A.M., the DON said: -He/She was not aware of the incident until the resident's family member called the SW and the SW notified him/her; -The Administrator was already on his/her way into the facility at the time of notification; -The facility began the investigation immediately; -He/She assessed the resident and no injuries were noted; -He/She and the Administrator watched the video and it was evident what happened, so DA A was called and terminated immediately; -Staff statements were taken and resident interviews were performed; -The resident's physician was notified and his/her family member was called back with an update; -The police were called and DA A was arrested for assault; -Staff had been previously in-serviced on abuse/neglect and when to report on 4/17/23, so they should have known to report it; -It was not acceptable for DA A to stay in the facility after the incident or to enter the smoking area with other residents present; -It is not acceptable for staff to place their hands on a resident's throat under any circumstances; -DA A was recently hired and educated on the Abuse and Neglect policy during orientation. During an interview of 5/2/24 at 12:30 P.M., the Administrator said: -The incident occurred on Sunday 4/28/24, but was not sure what time; -The facility administration was unaware of the incident until the resident's sibling called and notified them of the incident; -DA A was new to the facility and had only worked a few days at the time of the incident; -Staff was present when the incident occurred and did not report the incident to administration; (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Staff present did receive disciplinary action, a final warning due to the severity of the incident; -There was video of the incident; -DA A was terminated immediately after viewing the video; -The police were called and DA A was charged with simple assault and arrested. At the time of the abbreviated survey, the violation was determined to be at the immediate jeopardy level J. Based on observation, interview and record review completed during the on-site visit, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of the exit, the severity of the deficiency was lowered to the D level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action to be taken to address Class I violation(s). MO00235393 MO00235415

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 36151 Based on observation, interview and record review, the facility failed to ensure residents were free from unnecessary physical restraint when, in an attempt to keep a resident from wandering (Resident #20), Certified Nurse Aide (CNA) E picked the resident up, placed the resident over his/her shoulder and carried the resident to a chair. CNA E then tied a sheet to the chair, around the resident, to prevent the resident from getting up. The sample was 20. The facility census was 135. Review of the facility Abuse and Neglect Policy, dated 4/7/2017, revised on 1/19/2022, showed: -PURPOSE: To outline procedures for reporting and investigating complaints of abuse, neglect, and misuse of funds/ property, and to define terms of types of abuse/neglect and misappropriation of funds and property. To ensure immediate reporting of all abuse allegations to the Administrator or designee and the Director of Nursing (DON) or designee and outside persons or agencies. To establish actions related to the alleged perpetrator and to ensure investigation and assessment of all residents involved is completed; -DEFINITIONS: -Involuntary Seclusion is defined as separation of a resident from other residents or from his/her room against the resident's will; -Physical Abuse: Purposefully beating, striking, wounding, or injuring any resident or any manner whatsoever mistreating or maltreating a resident in a brutal or inhumane manner. Physical abuse includes handling a resident with any more force than is reasonable for a resident's proper control, treatment, or management. Physical abuse also includes, but is not limited to, hitting, slapping, punching, biting, and kicking. Physical abuse also includes corporal punishment, which is physical punishment. used to correct or control behavior; -Involuntary Seclusion is defined as separation of a resident from other residents or from his/her room against the resident's will; -Restraints: It is the policy of the Facility that every resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. It is also the policy of this Facility that every resident has the right to be free from verbal, sexual, physical, or mental abuse, corporal punishment, and involuntary seclusion; -Mistreatment, neglect, or abuse of residents is prohibited by this Facility. This includes physical abuse, sexual abuse, verbal abuse, mental abuse, and involuntary seclusion. Abuse includes deprivation of goods or services by staff that are necessary to attain or maintain physical, mental, and psychosocial well-being. In these cases, staff has the knowledge and ability to provide care and services, but chose not to do it, or acknowledge the request for assistance from a resident, which results in care deficits to a resident; (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Staff Supervision: On a regular basis, supervisors will monitor the ability of the staff to meet the needs of residents and staffs understanding of individual resident care needs. Situations such as inappropriate language, insensitive handling, or impersonal care will be corrected as they occur. Incidents short of willful abuse will be handled through counseling, training, and if necessary or repeated, the Facility's progressive discipline policy; -Reporting and Investigating Allegations: -Reporting to Supervisor/Administrator/Director of Nursing Employees and vendors are required immediately to report any occurrences of potential mistreatment, including alleged violations, mistreatment, neglect, abuse, sexual assault, and injuries of unknown; -Employees accused of possible mistreatment shall not complete the shift and will immediately be sent home. Review of Resident #20's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/8/23, showed: -Cognitively impaired; -Diagnoses included dementia. Review of the resident's care plan, in use during the investigation, showed: -Focus: Resident is at risk of Elopement due to wandering without purpose; -Interventions: Complete Elopement Assessment on admission, readmission and quarterly. Face Checks/Intensive monitoring will be completed per facility protocol; -Focus: Resident has manifestations of behaviors related to his/her mental illness that may create disturbances that affect others. These behaviors include wandering into peers' rooms and laying on the bed and rummaging through items. Resident was a drummer throughout his/her life and swings his/her arms around putting the resident at risk for unintended injury; -Interventions: If resident is disturbing others, encourage him/her to go to a more private area to voice concerns/feelings to assist in decreasing episodes of disturbing others. Provide 1:1 as needed per Administration discretion; - Focus: On 12/04/23, staff contacted the DON to state he/she believes she observed resident tied to a chair with a sheet in his/her room. The resident is on 1:1 monitoring, and the staff member states he/she believes that the 1:1 staff member was the person that tied the resident to the chair. Date Initiated: 12/05/2023; (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Staff member that was accused was immediately removed from this assignment. Staff immediately untied the resident. Skin and pain assessments completed and within normal limits. Accused staff member was suspended pending investigation. All staff to be reeducated on abuse and neglect policy, Intensive monitoring, and when to report. The resident will remain on 1:1 monitoring for safety and protective oversight. Review of the facility's initial investigation, showed; -Date and time of alleged incident, 12/04/2023 at 7:10 P.M.; -Staff contacted this nurse and stated that he/she believed he/she observed a resident tied to a chair with a sheet in his room. This resident was on one-on-one monitoring and was assigned a personal staff member 24 hours a day. The staff member stated he/she believed that the one-on-one staff member tied the resident to the chair. The staff member reported to the charge nurse, then placed a call to this DON. The charge nurse immediately removed staff member from assignment and called this nurse for further instruction. Staff member removed from facility and placed on suspension pending findings of allegation. Staff re-educated on abuse, neglect, intensive monitoring, and when/what to report. The resident received a thorough head to toe skin assessment and a pain assessment. Review of the facility investigation summary, undated, showed: -The investigation yields that there was a sheet tied to the arms of the chair thus acting as a restraint for this resident, there was never any object tied to the resident. This was observed by the staff member who reported to this nurse and staff member stated to this nurse that he/she removed the sheet that was tied to the arms of the chair. The staff member accused of these actions has subsequently been terminated. This resident will continue to receive one on one monitoring; -Nurse Aide (NA) D's statement, dated 12/4/23, showed, around 5:30 P.M. to 6:00 P.M., he/she walked on the 100 Hall to let a resident into the secured unit. NA D witnessed the resident being restricted in a chair with a sheet wrapped around both arms of the chair. NA D asked why the resident was like that and CNA E said because he/she always went into other resident's room. NA D told CNA E he/she usually walked him/her around the building. During an interview on 12/7/23 at 1:35 P.M., NA D said he/she saw the resident tied to a chair. The resident was sitting with a sheet across his/her waist. NA D said he/she saw it was tied. NA D went into the hall to let another resident onto the hall. NA D said the resident would get real agitated and was a wanderer. NA D asked CNA E why the resident was like that. CNA E said he/she wanted the resident there because he/she walked around and went into other rooms. NA D told CNA E he/she usually walked the resident around. NA D got mad seeing that, it was a form of restraint. NA D reported this to Nurse A. NA D didn't go right away to Nurse A with the information. He/She had to re-evaluate what he/she saw and take it all in. NA D said there were no signs posted to show restrictions like that were not allowed. NA D didn't know the rules in this building. He/She kept thinking it was not a lap buddy (a cushioned device that fits in a wheelchair to remind a person not to get up). NA D had just returned to nursing and it had been so long. Restraints used to be ok. Later, while at the nurse's station, he/she said something to Certified Medication Technician (CMT C) about CNA E. CMT C said he/she didn't like the way CNA E man-handled the resident earlier that day. NA D told CMT C that CNA E had the resident tied to a chair. Nurse A was present and texted the DON for permission to send CNA E home. CNA E was escorted out of the building. (continued on next page)

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F 0604

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Review of the facility investigation employee statements, showed on 12/4/23, a handwritten statement signed by CMT C, documented he/she witnessed CNA E pick the resident up like he/she was a baby. CMT C told CNA E not to do that. CNA E was very agitated with the resident.

During an interview on 12/7/23 at 1:40 P.M., CMT C said he/she saw CNA E pick the resident up like a baby. He/She did not see the resident tied to the chair. CNA E picked the resident up and walked with him/her to the chair the way you would pick up a baby. CNA E grabbed the resident behind his/her kneecaps and tried to put the resident over his/her shoulder, but the resident was too big for that. CMT C told CNA E he/she could not do that; the resident could walk. CMT C then continued to pass medications on the hall. CMT C said he/she felt CNA E was a little agitated working with the resident. He/She kept commenting the resident shouldn't be there. He/She asked if CMT C had some medicine for the resident. CNA E wanted the resident to just sit there. The resident walked around, that was his/her behavior. CMT C said he/she would not give a medication ordered as needed (PRN) for something that's controllable. It was the resident's behavior. CNA E carried the resident back to the chair, about 12 feet away. The resident didn't protest. CNA E treated the resident like a child. He/She took the resident's hand and pulled him/her around. CMT C made a phone call to switch CNA E out because it wasn't a good fit. He/She talked to the Human Resources Director (HRD), and took it to Nurse A. Nurse A said to switch CNA E out. CMT C told the HRD that CNA E picked the resident up. He/She didn't know about the tie up until they were at the nurse's station talking about it. One aide said he/she saw the resident tied to the chair. This was a no restraint facility.

Review of the facility investigation, HRD employee statement, dated 12/5/23, showed, a handwritten statement, signed by the HRD. He/She was not aware of the incident that occurred when a resident was alleged to have been tied to a chair. The HRD received a call from Social Services stating an employee refused to switch halls due to a nurse feeling uncomfortable with an aide working a 1:1. The HRD called the nurse to see if and why the employee refused and to instruct him/her on sending the aide home if the aide refused. The nurse said the aide did not refuse. He/She just wanted to know why he/she was being moved. Thirty minutes later, the HRD received a call from the DON about another incident that was reported. The same employee had allegedly tied the resident to the chair. An investigation was started and the employee was immediately sent home.

During an interview on 12/6/23 at 1:46 P.M., CNA E said he/she was on a 1:1 with the resident. He/She moved the resident from his/her room into the common area because the resident kept waking up his/her roommate. CNA E put the resident in a chair. Another aide said the resident had a sheet on him/her, like a seat belt. The resident had a sheet on his/her chair, but never on his/her body. The sheet was around the resident, tied like a seat belt to the chair, instead of tying it to the resident. CNA E thought this might help the situation. Staff are to keep the resident from harming someone or him/herself. CNA E said they were all false allegations. CNA E did pick the resident up to take him/her back to the chair in a bear hug. He/She playfully took the resident back to his/her seat. When other staff came on the hall, CNA E knew something was wrong. Nothing was communicated to him/her. He/She was taken off the 1:1 and was moved to a different section of the hall. If it was so detrimental, they should have said something earlier. This was around 8:00 P.M. or 9:00 P.M., then fifteen to twenty minutes later, they said he/she needed to clock out and go home.

On 12/8/23 at 1:51 P.M., the Regional Director said she expected the nurse to have intervened and immediately remove CNA E from the hall. Any staff member aware of an allegation of abuse were to immediately separate the alleged perpetrator from residents. CNA E was educated two weeks earlier. CNA E was educated and was not new to behavioral health. He/She knew how to properly do things.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MO00228368

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34926 Based on interview and record review, the facility failed to follow their abuse and neglect policy by not reporting timely after an allegation of physical abuse was made for one resident and an allegation of sexual abuse was made for another resident. This affected two residents (Resident #101 and Resident #109). The sample was 11. The census was 146. Review of the facility's Abuse and Neglect Policy, revised 1/5/23, included: -Purpose: --To outline procedures for reporting and investigating complaints of abuse, neglect, and misuse of funds/property, and to define terms of types of abuse/neglect and misappropriation of funds and property. To ensure immediate reporting of all abuse allegations to the Administrator or designee and the Director of Nursing or designee and outside persons or agencies. To establish actions related to the alleged perpetrator and to ensure investigation and assessment of all residents involved is completed. -Reporting to Supervisor/Administrator/Director of Nursing: --Employee and vendors are required immediately to report any occurrences of potential mistreatment including alleged violations, mistreatment, neglect, abuse, sexual assault, and injuries of unknown source and misappropriation of resident property they observe, hear about or suspect to a Supervisor or the Administrator. All residents, visitors, volunteers, family members or others are encouraged to report their concerns or suspected incidents of potential mistreatment to a Supervisor or the Administrator or to the Compliance Hotline. Such reports may be made without fear of retaliation. Anonymous reports will also be thoroughly investigated. -This Facility does not condone resident abuse by anyone, including employees, physicians, consultants, volunteers, and staff of other agencies serving the resident, family members, legal guardians, sponsors, other residents, friends, or other individuals. It is the responsibility of employees, Facility consultants, attending physicians, family members and visitors etc, to promptly report any incident or suspected incident of abuse/neglect/misappropriation of funds to Facility management immediately. If such incidents occur after hours the Administrator or designee and Director of Nursing or designee will be notified at home or by cell phone and informed of any such incident. -Report to State, Law Enforcement, and Others: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	--The facility must ensure that all alleged violations involving abuse, neglect, exploitation, mistreatment, or sexual assault including injuries of unknown source and misappropriation of resident property, are reported immediately, but no later than 2 hours after the allegation in made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the State Survey Agency. While specific forms are not required, the DHSS Initial Reporting Form and Follow-up Investigation Form are attached. If the abuse involves alleged suspicion of crime, it must also be reported to local law enforcement within those time frames. See Elder Justice Act - Reporting Reasonable Suspicion of a Crime -The facility will also notify the resident or their guardian legal representative. -Investigation: --Upon learning of the report of abuse or neglect, the Administrator shall initiate an incident investigation. --The nursing staff is additionally responsible for reporting and investigating the appearance of bruises, lacerations. or other abnormalities as they occur. Upon report of such occurrences, the nursing supervisor is responsible for assessing the resident, reviewing the documentation, and reporting to the Administrator or designee. 1. Review of the facility's in-service date 4/17/24, showed: -The in-service education included the abuse and neglect policy, who is a designated reporter and when to report an incident and to whom it should be reported; -Registered Nurse (RN) E signed the in-service indicating he/she received and understood the education; -Certified Nursing Assistant (CNA) C signed the in-service indicating he/she received and understood the education; -Certified Medication Technician (CMT) D signed the in-service indicating he/she received and understood the education; -Floor Technician (FT) B was not listed on the in-service roster indicating he/she did not receive the in-service education. Review of Resident #101's Admission Record showed the resident was admitted to the facility on [DATE] with diagnoses that included bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), hearing loss, legal blindness and dyskinesia (involuntary, erratic, writhing movements of the face, arms, legs or trunk). Review of the resident's quarterly Minimum Data Set (MDS) a federally mandated assessment instrument completed by facility staff, dated 1/29/24, showed: -Cognitively intact; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Ability to hear (with hearing aid or hearing appliances if normally used): Adequate. No difficulty in normal conversation, social interaction, listening to TV; -Hearing Aid or other hearing appliance used: No; -Speech Clarity: Unclear Speech: Slurred or mumbled words; -Ability to express ideas and wants, consider both verbal and nonverbal expression: Usually understood. Difficulty communicating some words or finishing thoughts but is able if prompted or given time; -Ability to understand others, understanding verbal content, however able (with hearing aid or device if used): Understands. Clear comprehension; -Ability to see in adequate light: Moderately impaired. Limited Vision, not able to see newspaper headlines but scan identify objects. -Corrective Lenses: No; -How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy? Never; -Psychosis: None; -Behavioral Symptoms: --Physical behavioral symptoms directed towards others: Behavior not exhibited; --Verbal behavioral symptoms directed towards others: Behavior not exhibited; --Other behavioral symptoms not directed toward others: Behavior not exhibited; -Rejection of Care: Behavior not exhibited; -Wandering: Behavior not exhibited. Review of the resident's electronic progress notes for the months of April 2024 and May 2024, showed: -4/28/24 at 8:00 P.M.: Staff will continue to monitor for protective oversight; -4/29/24 at 7:18 A.M.: Late Entry: Resident stated staff member put (his/her) hands around my neck and choked me. Head to toe skin assessment. No apparent injury noted. No bruising or discoloration noted. Placed call to the resident's physician and guardian and made them aware of incident. Administrator, Director of Nursing (DON) and Social Service aware. No complaints of pain of discomforted at present time; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265823	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestwood Health Care Center, LLC	11400 Mehl Avenue Florissant, MO 63033

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-4/30/24 at 9:06 A.M.: Law enforcement was notified of the staff to resident incident that occurred on 4/28/24; -4/30/24 at 9:53 A.M.: Resident's guardian notified Social Services Director (SSD) of an assault on resident by staff member. Allegation was investigated and law enforcement was called in. SSD spoke with resident on how he/she was feeling; resident appeared to be doing fine and stated he/she was doing ok. SSD will follow up with resident over the next 72 hours. Review of the facility's online report to the Missouri Department of Health and Senior Services (DHSS) showed the facility reported the incident to DHSS on 4/29/24 at 4:19 P.M. Review of the facility's Administrator/RN Investigation dated 4/30/24, showed: -Date of incident: 4/29/24; -Type of incident: Alleged abuse; -Person(s) involved in the incident: --Resident #101; --Dietary Aid (DA) A; -Witnesses: --FT B; --CNA C; --CMT D; -Statements received from witnesses: Yes; -Statement received from affected person(s): Yes; -Supportive intervention documentation attached: Yes; -Guardian notified of the incident: Yes; -By whom: Social worker; -Date and time notified: 4/29/24 at 2:00 P.M.; -Physician notified of incident: Yes; -By whom: Resident Care Coordinator (RCC); -Date and time: 4/29/24 at 2:30 P.M.; (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Documentation of incident completed: Yes; -By whom: RCC; -Disciplinary action required: Yes; -Narrative Note: The resident went to the kitchen door attempting to get coffee and was unsuccessful as DA A sent him/her away from the door. The resident walked to the back of the dining room then came back up to the dietary door where the alleged abuser was standing. The resident walked up asking DA A for coffee again when DA A started to take a stance with the resident, causing the resident to move his/her hands towards DA A. DA A then attempted to grab the resident in the neck area. Another resident was standing there and he/she was able to get the resident to move back from DA A. CMT D walked into the dining room and noticed that DA A was holding the resident's arms. CMT D then rushed up to see what was going on and officially removed the resident away from DA A. CMT D began to question DA A and was told that the resident wanted coffee and was told that there was none left, DA A added that the resident then came back trying to gain entrance into the kitchen so DA A was attempting to stop the resident. CMT D did not see DA A's hands around the resident's neck. CMT D simply thought it was a misunderstanding. CMT D also took the time to educate DA A, who is a new worker and had been working in the facility for maybe a week. The resident's sister called the social worker on 4/29/24, to ensure that the facility knew what had occurred. We then started a full investigation. Head to toe assessment done on the resident showed no injuries; -Conclusion/Outcome of the Investigation: All other residents were interviewed to ensure they are safe and that they felt safe. Abuse and neglect in-service also began again, in light of what happened. We also interviewed staff that may have seen this event and carried out disciplinary actions. I went to assess the resident again for any physical or mental wound. He/She appears to be ok. None noted at this time. The resident is VERY hard of hearing which poses a problem as well. If he/she can't hear to understand and in this case the staff was new, it can cause an issue for the resident and staff; -Care plan changes and interventions: Facility will follow up on the resident's hearing aids to see why he/she doesn't have them and get them. Will speak to his/her family as well; -Employee witness statement obtained; -The care plan must reflect new interventions as a result of this behavior emergency crisis: See about why he/she is not wearing hearing aids. -Signed by the Administrator and DON, dated 5/1/24. Review of the facility provided video evidence on 5/2/24 at 12:38 P.M., showed: -Resident #101 was noted in the dining room walking towards the kitchen area and DA A walked to stand in front of the resident; -At time stamp 00:09, DA A grabbed for the resident using his/her right hand, the resident grabbed DA A's right hand with his/her left hand; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-At time stamp 00:11, DA A grabbed towards resident's right shoulder/neck area with his/her left hand, then also moved his/her right hand to the resident's throat with the resident still trying to hold the right hand back; -At time stamp 00:15, the resident was able to step back and push DA A's hands off his/her throat; -At time stamp 00:16, FT B stepped in between DA A and the resident. FT B did not remove the resident from the situation or request DA A to move away from the resident; -At time stamp 00:25, FT B turned his/her back on DA A and the resident and started walking away; -At time stamp 00:26, CMT D was approaching at this time. DA A started stepping forwards again towards the resident; -At time stamp 00:28, CMT D put his/her arm out and blocked DA A from moving towards the resident and motioned for him/her to walk away and started speaking with the resident; -At time stamp 00:32, DA A was no longer visible in the video. FT B was walking towards the direction of DA A; -At time stamp 00:34, FT B stood between the resident and the direction DA A walked; -At time stamp 00:49, CMT D was still standing in the same place in the dining room talking with the resident, and the video ended. During an interview on 5/2/24 at 1:45 P.M., Resident #101 said: -He/She is very hard of hearing; -When attempting to write questions for the resident since he/she had difficulty hearing/understanding, the resident said he/she was legally blind and could not read the question; -DA A grabbed him/her around the throat for asking for coffee; -He/She was not hurt at the time, just surprised; -He/She knows one thing, he/she will never ask for coffee again if this is what is going to happen; -He/She feels safe in the facility since DA A no longer works at the facility; -Resident was unable to understand any other questions asked. During an interview on 5/2/24 at 2:35 P.M., DA A said: -One of the residents walked up to him/her by the kitchen door requesting coffee; -DA A told the resident there was no more coffee; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident told DA A to move out of his/her way. The resident was going to try to go in the kitchen; -DA A told the resident no; -The resident raised his/her arms and then DA A raised his/her arms; -DA A then grabbed the resident's neck and was in defense mode; -Someone called a Code Green (emergency behavior call for assistance) but no one came; -He/She had not been properly trained. He/She had orientation and started the next day in the kitchen; -In orientation, he/she learned one step ahead of the other. That means if a resident attacks you, you can defend yourself; -They didn't teach to ask for help or verbally de-escalate. They taught us nothing and then he/she started the next day; -He/She tried to get set up for the 1:1 training; -He/She was told to tell residents who ask that there was no more coffee; -The kitchen was being closed as it was almost 8:00 P.M.; -DA A doesn't make coffee and was told not to by the Supervisor; -He/She said the residents get coffee at breakfast, lunch and dinner; -The resident showed aggressiveness by raising his/her arms; -He/She resident grabbed DA A's arm and he/she was showing strength; -DA A showed his/her defense move and grabbed the resident's neck; -When asked if they discussed abuse -verbal and physical at orientation, he/she said they didn't get into any details; -If he/she had proper training he/she wouldn't be going through this; -He/She was never told the proper protocol; -He/She defended himself/herself; -When asked if he/she would consider his/her actions physically abusive, he/she said you can't skip to that part when asking about his/her actions. This was a reaction to the resident showing his/her physical strength. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/2/24 at 3:23 P.M., CMT D said: -He/She was on the CMT cart and walking to the kitchen for ice when he/she heard someone yell out Code Green; -CMT D noted DA A holding Resident #101 by the throat; -CMT D ran over and told DA A You can't hold (him/her) like that; -CMT D did not see the altercation. He/She did not enter the dining room until after it was over and FT B intervened; -CMT D did not report the incident to Administration because he/she saw RN E in the dining room performing blood sugar checks when he/she entered the dining room; -CMT D assumed RN E would write up the incident and notify Administration when RN E finished blood sugar checks. During an interview on 5/2/24 at 3:34 P.M., CNA C said: -He/She was standing in the doorway of the smoking room, smoking general population, when he/she heard a commotion coming from the dining room. He/She looked up and saw DA A with his/her hands on Resident #101; -He/She yelled a Code Green; -He/She saw two staff members intervene; -He/She did not report the incident because he/she thought the staff who intervened would tell the nurse and report it; -He/She received a written disciplinary warning and was in-serviced on abuse/neglect, when to report and resident rights on 4/30/24, which was his/her first day back to work after the incident occurred; -He/She will report it himself/herself from now on. During an interview on 5/2/24 at 3:50 P.M., FT B said: -He/She was standing in the dining room and witnessed the altercation; -He/She did not report the incident because someone else called the Code Green, so he/she wasn't aware that he/she needed to report it; -He/She assumed the person who yelled Code Green would report it and it would be on video and they would question him/her about it; -He/She did receive a written warning for not reporting the incident; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She did receive abuse and neglect in-servicing earlier in April and again after this incident; -He/She now knows to report all incidents, even if he/she thinks someone else is reporting it also. During an interview on 5/3/24 at 10:39 A.M., RN E said: -He/She did not witness the incident; -The dining room was loud and he/she did not hear the incident or the staff yell out Code Green; -No one reported the incident to him/her; -He/She did not assess the resident after the incident; -To his/her knowledge, the other nurse on duty, Licensed Practical Nurse (LPN) F, was not notified and did not assess the resident either; -Staff should have notified him/her or LPN F of the incident; -If he/she was notified, he/she would have pulled DA A off the floor immediately and sent him/her home; -He/She would have then notified Administration, the resident's physician and family; -He/She did not work the next day and did not know about the incident until the DON called on 4/29/24 to ask if he/she was aware of the situation and what actions were taken, if any. During an interview on 5/3/24 at 10:48 A.M., the DON said: -He/She was not aware of the incident until Resident #101's family member called the SSD and the SSD notified him/her on 4/29/24; -The Administrator was already on his/her way into the facility at the time of notification; -The facility began the investigation immediately; -Staff statements were taken and resident interviews were performed; -The resident's physician was notified and his/her family member was called back with an update; -The police were called and DA A was arrested for assault; -Staff was in-serviced on abuse/neglect, when to report and resident rights on 4/29/24; -Staff had been previously in-serviced on abuse/neglect and when to report on 4/17/23, so they should have known to report it; -DA A was recently hired and educated on the Abuse and Neglect policy during orientation. (continued on next page)

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F 0609

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

During an interview of 5/2/24 at 12:30 P.M., the Administrator said:

-The incident occurred on 4/28/24, but was not sure what time the incident occurred;

-The facility was unaware of the incident until Resident #101's sibling called and notified them of the incident on 4/29/24;

-Staff were present when the incident occurred and did not report the incident to administration;

-Staff present did receive disciplinary action, a final warning due to the severity of the incident;

-There was video of the incident;

-DA A was terminated immediately after viewing the video;

-The police were called on 5/30/24 and DA A was charged with simple assault and arrested;

-The facility immediately started in-servicing staff on abuse and neglect, when to report and resident rights.

2. Review of Resident 109's annual MDS, dated [DATE], showed:

-Cognitively intact;

-Behavioral Symptoms:

-Physical behavioral symptoms directed towards others: Behavior not exhibited;

-Verbal behavioral symptoms directed towards others: Behavior not exhibited;

-Other behavioral symptoms not directed toward others: Behavior not exhibited;

-Diagnoses include anxiety, manic depression, schizophrenia, seizures and Post Traumatic Stress Disorder (PTSD).

Review of the resident's progress note, dated 5/3/24 at 10:34 P.M., showed this resident came to this writer, LPN G, accusing another resident of being sexually inappropriate with him/her. Resident was unable to give a date or a time, and states it was before this resident moved over to a hall on a locked unit. Call placed to management, and resident's guardian to make them aware. Physician also made aware.

Review of the online reporting shows the allegation was submitted to DHSS on 5/4/24 at 12:59 P.M.

-Review of the facility's investigation, received 5/6/24 at 4:30 P.M., showed:

-The date/time of the incident was on 5/1/24 at 12:00 A.M. and reported by the Charge Nurse.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/6/24 at 2:52 P.M., the Administrator said all allegations of abuse and neglect should be reported within 2 hours. He said the facility should have notified DHSS on 5/3/24 about the incident involving Resident #109. MO00235393 MO00235415 MO00235645

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F 0610

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Respond appropriately to all alleged violations.

36151

Based on interview and record review, the facility failed to follow their policy when staff observed a staff member (Certified Nurse Aide (CNA) E) use a sheet to restrain a resident (Resident #20) to a chair because the resident wandered. The facility also failed to ensure staff were aware of their Abuse and Neglect Policy when Nurse Aide (NA) D observed the resident restrained and did not immediately report it because he/she was unsure if restraints were allowed. In addition, Certified Medication Technician (CMT) C observed CNA E pick up the resident and carry him/her to a different area. CNA E asked CMT C for medication to make the resident stop wandering. CMT C failed to immediately report this. Upon being made aware of the allegations, staff failed to immediately send CNA E home. Instead, staff assigned CNA E to a different area, and he/she continued to provide resident care for approximately twenty minutes. The census was 135.

Review of the facility Abuse and Neglect Policy, dated 4/7/2017, revised on revised on 1/19/2022, showed:

-PURPOSE: To outline procedures for reporting and investigating complaints of abuse, neglect, and misuse of funds/ property, and to define terms of types of abuse/neglect and misappropriation of funds and property. To ensure immediate reporting of all abuse allegations to the Administrator or designee and the Director of Nursing (DON) or designee and outside persons or agencies. To establish actions related to the alleged perpetrator and to ensure investigation and assessment of all residents involved is completed;

-DEFINITIONS:

-Physical Abuse: Purposefully beating, striking, wounding, or injuring any resident or any manner whatsoever mistreating or maltreating a resident in a brutal or inhumane manner. Physical abuse includes handling a resident with any more force than is reasonable for a resident's proper control, treatment, or management. Physical abuse also includes, but is not limited to, hitting, slapping, punching, biting, and kicking. Physical abuse also includes corporal punishment, which is physical punishment used to correct or control behavior;

-Involuntary Seclusion is defined as separation of a resident from other residents or from his/her room against the resident's will;

-Restraints: It is the policy of the Facility that every resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. It is also the policy of this Facility that every resident has the right to be free from verbal, sexual, physical, or mental abuse, corporal punishment, and involuntary seclusion;

-Prevention and Identification: The Facility will provide residents, family and staff, information on how and to whom they may report concerns, incidents, and grievances without the fear of retribution and provide feedback on the concerns that they have expressed;

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Facility will identify and correct by providing interventions in which abuse, neglect or misappropriation of resident property is more likely to occur. This will include staff are knowledgeable of resident care needs. Supervisors should identify inappropriate behaviors such as neglectful care; -Reporting and Investigating Allegations: -Reporting to Supervisor/Administrator/Director of Nursing: Employees and vendors are required immediately to report any occurrences of potential mistreatment, including alleged violations, mistreatment, neglect, abuse, sexual assault, and injuries of unknown; -Employees accused of possible mistreatment shall not complete the shift and will immediately be sent home. Review of Resident #20's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/8/23, showed: -Cognitively impaired; -Diagnoses included dementia. Review of the resident's care plan, in use during the investigation, showed: -Focus: Resident has manifestations of behaviors related to his/her mental illness that may create disturbances that affect others. These behaviors include wandering into peers' rooms and laying on the bed and rummaging through items. Resident was a drummer throughout his/her life and swings his/her arms around putting the resident at risk for unintended injury; -Interventions: If resident is disturbing others, encourage him/her to go to a more private area to voice concerns/feelings to assist in decreasing episodes of disturbing others. Provide 1:1 as needed per Administration discretion; - Focus: On 12/4/23 staff contacted the DON to state he/she believes he/she observed resident tied to a chair with a sheet in his/her room. The resident is on 1:1 monitoring, and the staff member states he/she believes that the 1:1 staff member was the person that tied the resident to the chair. Date Initiated: 12/05/2023; -Staff member that was accused was immediately removed from this assignment. Staff immediately untied the resident. Skin and pain assessments completed and within normal limits. Accused staff member was suspended pending investigation. All staff to be reeducated on abuse and neglect policy, Intensive monitoring, and when to report. The resident will remain on 1:1 monitoring for safety and protective oversight. Review of the facility's initial investigation, showed; -Date and time of alleged incident, 12/04/2023 at 7:10 P.M.; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Staff contacted this nurse and stated that he/she believed he/she observed a resident tied to a chair with a sheet in his/her room. This resident was on 1:1 monitoring and was assigned a personal staff member 24 hours a day. The staff member stated he/she believed that the 1:1 staff member tied the resident to the chair. The staff member reported to the charge nurse, then placed a call to this DON. The charge nurse immediately removed staff member from assignment and called this nurse for further instruction. Staff member removed from facility and placed on suspension pending findings of allegation. Staff re-educated on abuse, neglect, intensive monitoring, and when/what to report. The resident received a thorough head to toe skin assessment and a pain assessment. Review of the facility's investigation summary, undated, showed: -The investigation yields that there was a sheet tied to the arms of the chair thus acting as a restraint for this resident, there was never any object tied to the resident. This was observed by the staff member who reported to this nurse and staff member stated to this nurse that he/she removed the sheet that was tied to the arms of the chair. The staff member accused of these actions has subsequently been terminated. This resident will continue to receive 1:1 monitoring; -NA D's handwritten statement, dated 12/4/23, signed by NA D, documented around 5:30 P.M. to 6:00 P.M., showed he/she walked on the 100 Hall to let a resident into the secured unit. NA D witnessed the resident being restricted in a chair with a sheet wrapped around both arms of the chair. NA D asked why the resident was like that and CNA E said because he/she always went into other residents' rooms. NA D told CNA E he/she usually walked the resident around the building. During an interview on 12/7/23 at 1:35 P.M., NA D said he/she saw the resident tied to a chair. The resident was sitting with a sheet across his/her waist. NA D said he/she saw it was tied. NA D went into the hall to let another resident onto the hall. NA D reported this to Nurse A. NA D didn't go right away to Nurse A with the information. He/She had to re-evaluate what he/she saw and take it all in. NA D was not sure if the facility allowed restraints. Later, while at the nurse's station, he/she said something to Certified Medication Technician (CMT C) about CNA E. CMT C said he/she didn't like the way CNA E man-handled the resident earlier that day. NA D told CMT C that CNA E had the resident tied to a chair. Nurse A was present and texted the DON for permission to send CNA E home. CNA E was escorted out of the building and NA D had to write a statement and escorted him/her out. Review of the facility's investigation, showed on 12/4/23, a handwritten statement signed by CMT C, showed he/she witnessed CNA E pick the resident up like he/she was a baby. CMT C told CNA E not to do that. CNA E was very agitated with the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265823	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/08/2023
NAME OF PROVIDER OR SUPPLIER Crestwood Health Care Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 11400 Mehl Avenue Florissant, MO 63033	

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/7/23 at 1:40 P.M., CMT C said he/she saw CNA E pick the resident up like a baby. He/She did not see the resident tied to the chair. CNA E picked the resident up and walked with him/her to the chair the way you would pick up a baby. CNA E grabbed the resident behind his/her kneecaps and tried to put the resident over his/her shoulder, but the resident was too big for that. CMT C told CNA E he/she could not do that; the resident could walk. CMT C then continued to pass medications on the hall. CMT C said he/she felt CNA E was a little agitated working with the resident. He/She kept commenting the resident shouldn't be there. He/She asked if CMT C had some medicine for the resident. CNA E wanted the resident to just sit there. The resident walked around, that was his/her behavior. CMT C said he/she would not give a medication ordered as needed (PRN) for something that's was not controllable. It was the resident's behavior. CNA E carried the resident back to the chair, about 12 feet away. The resident didn't protest. CNA E treated the resident like a child. He/She took the resident's hand and pulled him/her around. CMT C made a phone call to switch CNA E out because it wasn't a good fit. He/She talked to the Human Resources Director (HRD), and took it to Nurse A. Nurse A said to switch CNA E out. CMT C told the HRD that CNA E picked the resident up. He/She didn't know about the tie up until they were at the nurse's station talking about it. One aide said he/she saw the resident tied to the chair. This was a no restraint facility. Review of the facility investigation, dated 12/5/23, showed a handwritten statement, signed by the HRD. He/She was not aware of the allegation the resident had been tied to a chair. The HRD received a call from Social Services stating an employee refused to switch halls due to a nurse feeling uncomfortable with an aide working a 1:1. The HRD called the nurse to see if and why the employee refused and to instruct him/her on sending the aide home if the aide refused. The nurse said the aide did not refuse. The aide just wanted to know why he/she was being moved. Thirty minutes later, the HRD received a call from the DON about another incident that was reported. The same employee had allegedly tied the resident to the chair. An investigation was started and the employee was immediately sent home. During an interview on 12/6/23 at 1:46 P.M., CNA E said he/she was on a 1:1 with the resident. He/She moved the resident from his/her room into the common area because the resident kept waking up his/her roommate. CNA E put the resident in a chair. Another aide said the resident had a sheet on him/her, like a seat belt. The resident had a sheet on his/her chair, but never on his/her body. The sheet was around the resident, tied like a seat belt to the chair, instead of tying it to the resident. CNA E thought this might help the situation. CNA E did pick the resident up to take him/her back to the chair in a bear hug. He/She playfully took the resident back to his/her seat. When other staff came on the hall, CNA E knew something was wrong. Nothing was communicated to him/her. He/She was taken off the 1:1 and was put in a different area of the same hall. If it was so detrimental, they should have said something earlier. This was around 8:00 P.M. or 9 P.M. Fifteen to twenty minutes later, they said he/she needed to clock out and go home. On 12/8/23 at 1:51 P.M., the Regional Director said she expected the nurse to have intervened and immediately remove CNA E from the hall. Any staff member aware of an allegation of abuse were to immediately separate the staff from residents. CNA E was educated two weeks earlier. CNA E was educated and was not new to behavioral health. He/She knew how to properly do things. MO00228368

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F 0689

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 44950

Based on observation, interview and record review, the facility failed to provide protective oversight to one resident (Resident #30) with a known history of wandering and elopement, who resided on a locked unit. The resident eloped from the facility on 1/17/24, out of an alarmed door. Staff did not realize the resident had left until the resident was found at a gas station and brought back by the police over an hour after he/she was last seen by staff . In addition, the facility failed to complete elopement assessments per protocol, to include interventions to be implemented. The sample size was 22. The census was 140.

Review of the facility's Elopement Protocol policy, last revised 1/19/22, showed:

-Purpose: An elopement will be defined as any time a resident is missing from the facility or there is a possibility that a resident has left the facility without appropriate supervision and their whereabouts are unknown;

-Procedure: The first person aware of an elopement will call a Code [NAME] to the area of the believed elopement, if known;

-If the resident is believed to possibly still be inside the facility, the first person to be aware of the missing resident is to page for all units to search room to room for the resident. All rooms, closets, bathrooms, and work areas are to be searched;

-As soon as pages have been made, the Administrator is to be called immediately;

-If the resident has in fact left the facility, notify the resident's family or guardian. The person to notify the family or guardian will be designated by the Administrator;

-The facility will notify the local police;

-Dependent on the local law enforcement request of the facility, you may email a copy of the resident's electronic face sheet with photograph via secure email. Ensure the law enforcement officer you are emailing is aware of the resident information being sent;

-The Charge Nurse on duty will initiate facility grounds search. The Charge Nurse on duty will call the police to report the elopement when the resident is not found in the building or grounds. The Charge Nurse will provide the police department will the following information pertaining to the resident: Name, sex, age, time discovered missing, where resident was last seen and when, physical description (picture if available), physical Impairments, mental Impairments, language spoken, color and type of clothing worn, if the resident is harmful to self or others, home address of any known friends or relatives;

-The Administrator will initiate the emergency call list and coordinates the search;

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-As each person on the call list is notified, they will call the next person and then go to the facility to assist with the search; -After the resident has been located and returned to the facility: Notify the family or guardian, notify all persons involved in the search, perform a full body assessment, obtain vital signs, document all findings, notify the physician, complete the investigation elopement form, initiate intensive monitoring protocol upon return for attempted/actual elopement; -Notification of state agencies will be at the discretion of the Administrator/designee. Review of the facility's undated unit admission criteria for the locked behavioral units, classified as high behavior unit, showed: -No wheelchair/assistive devices unless short term use; -No assist of one, assist of two, or total care- must be independent with activities of daily living (ADLs); -No high elopement behaviors (high elopement defined as recent history of successful elopements/exit seeking). Review of Resident #30's admission Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff), dated 8/21/23, showed: -admitted : 8/11/23; -Cognitively intact; -Adequate hearing. Clear speech; -Makes self-understood and clear comprehension; -Wandering presence and frequency: 4-6 days but less than daily; -Does wandering place resident at significant risk of getting to a potentially dangerous place (stairs, outside of facility): No; -Does wandering significantly intrude on privacy of activity of others: No; -How does resident current behavior status, care rejection or wandering compare to prior assessment: N/A no previous assessment; -Diagnoses include manic depression, post traumatic stress disorder (PTSD), seizures, and high blood pressure. Review of the resident's progress notes, showed: -On 8/11/23 at 11:15 P.M., resident admitted to locked unit; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 8/12/23 at 7:18 P.M., resident cooperative with staff. Resident asked who he/she should talk to in order to get out of here. Review of the resident's care plan, focus dated and last revised 8/23/23 showed: Resident at risk for elopement due to expressing a desire to elope from facility and/or other verbally expresses desire to elope from facility and has the physical capability to do so: -Goal: Resident will be monitored closely and remain safe through next review; -Intervention: Complete elopement assessment on admission, readmission, and quarterly. Face checks/intensive monitoring will be completed per facility protocol. Review of the resident's medical record, showed no admission elopement assessment completed. Review of the resident's progress notes, showed: -On 8/25/23 at 4:57 P.M., receptionist informed this writer that resident has being calling 911 times three, stating he/she does not want to be here anymore, and he/she wants an ambulance to come and pick him/her up. At 7:57 P.M., Code [NAME] called, resident kicked locked unit hall door open and ran through the dining room and exited out of the side door. Resident is noted to be agitated, repeating self. Stating, I don't want to be here anymore. Explained resident that he/she will have to talk with administration on Monday. Guardian notified of resident's behavior. Review of the resident's Elopement Evaluation, dated 9/17/23 at 4:52 P.M., showed: -Does the resident have a history of or an attempted elopement while at home: Yes; -Does the resident have a history of or attempted leaving the facility without informing staff: Yes; -Has the resident verbally expressed the desire to go home, packed belongings to go home, or stayed near an exit door: Yes; -Elopement score 3 (at risk); -Clinical suggestions: No interventions selected. Review of the resident's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Adequate hearing. Clear speech; -Makes self-understood and clear comprehension; -Wandering presence and frequency: 4-6 days but less than daily; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Does wandering place resident at significant risk of getting to a potentially dangerous place (stairs, outside of facility): Blank; -Does wandering significantly intrude on privacy of activity of others: Blank; -How does resident current behavior status, care rejection or wandering compare to prior assessment: Blank; -Diagnoses include manic depression, PTSD, seizures, and high blood pressure. Review of the resident's progress notes, showed: -On 10/24/23 at 1:31 P.M., care plan meeting held on 10/18/23. Care team met with the resident and his/her guardian. Resident expressed not wanting to live in a facility for the rest of his/her life and expressed wanting to sign against medical advice (AMA) paperwork. The team discussed resident being moved to general population. The team ended the meeting with encouraging the resident to continue to make good/positive decisions; -On 12/28/23 at 3:20 P.M., resident is at nursing station telling staff he/she wants to leave AMA. Nurse notified resident that he/she has a guardian and cannot leave without their permission. Resident did not listen and continued to voice his/her opinions. Staff was able to redirect behavior. Will continue to monitor and report further behaviors. Review of the resident's Elopement Evaluation, dated 1/4/24 at 3:12 P.M., showed: -Does the resident have a history of or an attempted elopement while at home: Yes; -Does the resident have a history of or attempted leaving the facility without informing staff: Yes; -Has the resident verbally expressed the desire to go home, packed belongings to go home, or stayed near an exit door: Yes; -Does the resident wander: Yes; -Score value of 1 or higher indicates risk of elopement: Score not calculated; -Clinical suggestions: No interventions selected. Review of the resident's progress notes, showed: -On 1/7/24 at 3:46 P.M., resident standing at the front lobby door with backpack on. Resident agitated, stating he/she is signing out AMA and he/she is going to East St. Louis. Resident re-directed from the door multiple times. Resident then went to the lobby door and was hitting the window. Resident assisted to the locked unit hall for increased monitoring; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 1/17/24 at 11:00 P.M., St. Louis County Police Officer arrived to the facility via front entrance making Nurse V, aware resident had been noted at local gas station without assist of staff. Nurse V clarified Resident #30 was not noted in his/her room where he/she was last seen by this nurse, Certified Medical Technician (CMT), and partner nurse one hour prior. Nurse at this time notes the resident to be alert, able to make needs known, denying any pain and displays no distress upon assessment. Remains able to move all extremities without difficulty, resident assists self from police car and requests nurse send to the hospital at this time. Nurse asks resident where he/she is going, and resident makes nurse aware he/she no longer wants to live at the facility. Resident also at this time makes nurse aware he/she will not return to facility. Upon assessment nurse ensures resident's safety where resident makes nurse aware he/she no longer feels safe with self and will continue to exit seek until he/she reaches East St. Louis. Resident refuses to make nurse aware of exit or exit strategy. Upon attempting to find other interventions of assistance, resident makes nurse aware that he/she will refuse all intervention unless assisted to East St. Louis for new housing with family. With Police Officer present, resident agrees to hospital evaluation for further safety assessment post elopement. Call placed to physician to make aware with order to send to hospital for evaluation and treatment if indicated. Placed call to Guardian with no answer, detailed message left. The nurse called the after hours line for the guardian and made that person aware since the guardian did not answer. Nurse aware they will speak with hospital physician upon assessment at hospital. Ambulance arrives to facility to transport resident who continues to request transport to East St. Louis. Resident left facility via ambulance. Nurse V placed call to Emergency Dept and spoke with nurse to receive the resident upon arrival. Detailed report given to nurse highlighting elopement and resident's continued need to reach East St. Louis making him/her a high flight risk. Administration in facility aware. Review of the resident's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Adequate hearing. Clear speech; -Makes self-understood and clear comprehension; -Wandering presence and frequency: 1-3 days; -Does wandering place resident at significant risk of getting to a potentially dangerous place (stairs, outside of facility): Blank; -Does wandering significantly intrude on privacy of activity of others: Blank; -How does resident current behavior status, care rejection or wandering compare to prior assessment: Blank; -Diagnoses include manic depression, PTSD, seizures, and high blood pressure. Review of the facility's investigation, showed: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/24/24 at 12:45 P.M., Nurse A said he/she is not sure what happened on 1/17/24. Nurse A was on a locked unit hall when he/she thinks the resident got out of the facility so he/she would not hear the door alarm. The last time the resident was at the nurse's station that night was around 9:30 P.M. The resident does say he/she wants to leave but never made an advance to the doors. Nurse V was the resident's assigned nurse. They were not aware of the resident's absence until he/she walked through the door with the police around 11:30 P.M. The resident must have gotten out between 9:30 P.M. and 11:00 P. M. If the alarm had been heard, staff would have to check the doors, the panel by the nurse's station, do a head count, and notify administration. Nurses are supposed to do door checks hourly. During an interview on 1/24/24 at 2:20 P.M., Nurse V said he/she is an agency nurse and worked the evening shift on 1/17/24. He/She was the resident's assigned nurse. Between 9:30 P.M. and 10:00 P.M., the resident stood by the nurse's station to have bedtime snacks. Nurse V said the resident does this every night between 9:30 P.M. and 9:45 P.M. The resident wants an extreme amount of snacks like 10 bags of chips. The resident will say he/she did not eat lunch. Nurse V said he/she will give the resident two. That night he/she offered the resident an oatmeal cream pie. The resident said he/she would talk to the administrator tomorrow and go to bed. The resident went down the hall and to his/her room. Around 10:50 P.M., the police knocked at the front door with the resident. Nurse V said there was just staff in the building when the resident got out. The nurse thinks there were 3 or 4 certified nurse aides (CNAs), 2 certified medication technicians (CMTs), and 2 nurses. No alarm went off. Nurse V considers all residents elopement risks. The nurse had not been told the resident attempted to elope before that night. He/She is not sure what door the resident got out of, but the nurse remembers at the beginning of his/her shift, housekeeping staff set off the 400 hall door. That was the only alarm he/she heard. If an alarm goes off, there is a panel across from the nurse's station to notify which door. The door will continue to alarm if not shut. He/She was at the nurse's station charting from 9:30 P.M. until the resident was brought back by police. No staff would have let the resident out and there were no visitors. During an interview on 1/23/24 at 12:15 P.M., the administrator said the night of the elopement he was called around 11:00 P.M. by staff. The police showed up around that time. He watched the camera footage to know what door the resident opened. The video shows the resident exited around 10:30 P.M. - 10:45 P.M. the night of the elopement. The resident went out of the 400 hall which is a delayed egress alarmed door. The code has to be pushed to reset. It goes off at the door and then the nurse's station as well. There is a panel that tells what door is breached. He does not know what happened. There is no sound on the cameras to know if the alarm went off. Maintenance completes door checks two to three times a week. The door codes are changed every Friday. During an interview on 1/23/24 at 2:15 P.M., Resident #30 said he/she came from a different facility to be at this facility with the administrator. The resident likes the administrator. The resident says he/she has been at this facility for about 5 months. He/She did not elope from the facility, a staff member with braids let him/her out of the facility. It was out the 400 hall door. The alarm did not go off because the staff member entered the code. The resident said he/she told the staff member that he/she was going to Quick Trip to get a donut and that he/she would be back. The resident said he/she was not sure if the staff person was an aide or a nurse. He/she had not seen that staff person before that night. During an interview on 1/24/24 at 9:50 A.M., the social worker and administrator said they know staff did not let the resident out because they checked the video footage. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/24/24 at 9:15 A.M., Hall Monitor L said the resident has always said that he/she wanted to leave. During an interview on 1/23/24 at 11:45 A.M., the Maintenance Supervisor said he has been at the facility for two years. The night of the elopement he came up to the facility to verify every door alarm worked. Every alarm went off on the doors and the nurse's station. He said there is a box on the wall near the nurse's station that tells which door is open. Maintenance performed weekly tests before the elopement. He started to test all the doors. The regional maintenance supervisor was present during the tests. The doors on the general population units are egress doors. There is also a keypad on the wall next to the door. When the door handle is pushed in, the door beeps for 15 seconds then an alarm goes off after the 15 seconds or once the door is opened all the way. The alarm at the door stops once the door is shut. The alarm at the nurse's station continues until the keypad code is entered. There are two dining room exit doors. The one on the right does not beep as loud but still beeps and triggers the alarm at the nurse's station. If a resident went out one of the dining room doors, they would be trapped in the courtyard because there is a key code at the fence. The codes are changed every Friday. He would think if it were quiet or late at night, a person should be able to hear the initial beeps at the nurse's station due to the layout of the facility. There is no way to turn up or down the volume. They do not have control over that. All tested doors work. The box at the nurse's station will light up the corresponding door that opens. The maintenance supervisor said the behavioral locked units only have codes to get out. There are no egress doors to the outside. Observation at this time, during the door test, doors to 300 hall, 400 hall, and 500 hall were opened. Zone 3 and zone 5 lit up on the board to show those doors had opened. Zone 4, the door the resident exited, did not light up when the 400 hall door opened. The maintenance supervisor said it lit up the night of the elopement when he came in to check the doors, so he was not sure why it did not light up now. During an interview on 1/23/24 at 12:10 P.M., Nurse N, located at the nurses station during the observed door test, said the light on the board should correlate to the door that is open. If the 400 door is open, zone 4 should light up. Nurse N said if he/she hears a door alarm, but the zone is not lit up on the board then he/she would check all the doors to see which one opened. During an interview on 1/24/24 at 10:20 A.M., Nurse K said he/she has worked at the facility for 3 years. The resident has always tried to get out. He/she expresses frequently that he/she wants to go back to his/her old facility. If the resident was back in general population, he/she would try to get out. The resident will throw tantrums when he/she does not get what he/she wants. Nurse K said he/she is not aware of any staff that would let a resident out of the facility. If one of the door alarms go off, staff will check the board to see which door opened. Then staff do a whole house check, then initiate code white if a resident is missing. Nurses are supposed to do checks every hour. During an interview on 1/24/24 at 10:11 A.M., the resident's guardian said the facility called to report the incident on 1/18/24. The resident always wants to leave when the resident does not get what he/she wants. The resident was at a sister facility with the administrator and tried to get out there. The resident has tried to elope from both his/her previous facilities. The resident calls the guardian daily and always complains about something. The resident called on 1/17/23 wanting to leave. Regarding the staff member that let the resident out, the resident normally does not lie. The administrator knows the resident well. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Crestwood Health Care Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 11400 Mehl Avenue Florissant, MO 63033	

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/24/24 at 11:00 A.M., the administrator says if a resident eloped three months prior to coming to the facility, then the resident would not necessarily be considered an elopement risk. Elopement assessments are done on admission, quarterly, and with any changes. Staff address the high elopement risk by putting them on the locked unit. When the resident got to the facility on the locked unit, he/she had not eloped. Then the resident was placed in general population but continued to be monitored. The inter-disciplinary team completes the new resident review. If there is indication of potential elopement, IDT meets three times a week. The members of the IDT team include the admission coordinator, director of nursing (DON), MDS, activity director, social services, administrator, and dietary. He would expect staff to let him know if a change occurred. If it is documented a resident has tried to leave, he should be told. The resident's baseline was that he/she always said he/she wanted to leave. To the administrator's knowledge, the resident never tried to leave before the resident got out. The resident was not trying to elope, it was just behaviors. During an interview on 1/25/24 at 12:30 P.M., the Housekeeping Supervisor said if one of her staff sets off any door, they are expected to lock that door back when they come back in the facility. If someone leaves then employees should hear that sound and check then lock the door. If they do set off the alarm, then they turn the alarm off so door relocks again. No one should be leaving out any door but the main door. Sometimes they will use the back doors like 400 to take out the trash and that is ok. During an interview on 1/25/24 at 12:50 P.M., the Administrator said the elopement assessment should be completed within 24 hours of admission, quarterly with the care plan, as needed, and annually. He does not think it needs to be done on readmission. The elopement admission assessment should have been done before 9/17/23. If a resident elopes, then staff should redo the elopement assessment. The resident should not be on a locked unit unless the resident has eloped. Maintenance should be checking doors daily. Something happened with the 400 hall door. The vendor came out and looked at it. MO00230457

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36151 Based on interview and record review, the facility failed to ensure sufficient skilled and competent staff worked effectively with behavioral health residents when a staff person, who was assigned to provide one on one (1:1) intensive supervision to a resident (Resident #12) left the hall, leaving the hall insufficiently staffed. Soon after, a resident to resident altercation occurred between two residents (Resident's #11 and #12). The sample was 20. The facility census was 135. Review of the facility Abuse and Neglect Policy, dated 4/7/2017, revised on revised on 1/19/2022, showed: -PURPOSE: To outline procedures for reporting and investigating complaints of abuse, neglect, and misuse of funds/ property, and to define terms of types of abuse/neglect and misappropriation of funds and property. To ensure immediate reporting of all abuse allegations to the Administrator or designee and the Director of Nursing (DON) or designee and outside persons or agencies. To establish actions related to the alleged perpetrator and to ensure investigation and assessment of all residents involved is completed; -Physical Abuse: Purposefully beating, striking, wounding, or injuring any resident or any manner whatsoever mistreating or maltreating a resident in a brutal or inhumane manner. Physical abuse includes handling a resident with any more force than is reasonable for a resident's proper control, treatment, or management. Physical abuse also includes, but is not limited to, hitting, slapping, punching, biting, and kicking. Physical abuse also includes corporal punishment, which is physical punishment. used to correct or control behavior; -Prevention: The Facility will identify and correct by providing interventions in which abuse, neglect or misappropriation of resident property is more likely to occur. This will include assessment of the physical environment, which may make abuse or neglect more likely to occur, such as more secluded areas in the Facility, the deployment of staff on each shift in sufficient numbers to meet the resident's needs and that the staff are knowledgeable of resident care needs. Review of the Facility 1:1 staff reminders, showed: -DO NOT LEAVE YOUR 1:1; -You must stay with your 1:1 resident, 1:1 cannot be left by themselves for any reason; -You cannot leave your 1:1 unattended at any time; -Your 1:1 should always be within arm's reach; -When taking a break, someone must be assigned to watch your 1:1, do not leave your 1:1 to take a break; (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-When leaving at the end of your shift, do not leave your 1:1 until your relief has shown up and taken responsibility; -Your responsibility when assigned a 1:1 is to provide protective oversight for that individual; -Keep in mind that a resident is placed on 1:1 monitoring due to emergent reasons (falls, altercations, self-harm, etc.), you must take each 1:1 assignment seriously; -Disciplinary action, including up to termination could result from leaving your 1:1 unattended at any time. Review of Resident #12's quarterly Minimum Data Set (MDS), a federally mandated resident assessment completed by facility staff, dated 10/28/23, showed; -Cognitively intact; -Independent with ADLs; -Diagnoses included depression and Schizophrenia. Review of the resident's care plan, undated, showed; -Focus: Resident has a history of behavioral challenges that require protective oversight in a secure setting. Poor impulse control, poor safety awareness, agitation, property destruction, aggression, violent outbursts, poor decision making, poor attention span and hallucinations due to schizophrenia; Interventions: When resident is getting agitated, remove him/her from loud noises. He/she likes to use his/her tablet or phone to listen to music through headphone. Review of Resident #11's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Independent with all activities of daily living (ADLs); -Diagnoses included depression, anxiety, seizure disorder, traumatic brain injury and Schizophrenia (serious mental illness that affects how a person thinks, feels, and behaves). Review of the resident's care plan, undated, showed: -Focus: Has the potential to be verbally/physically/sexually aggressive due to diagnoses of Schizophrenia; -Intervention: When the resident becomes agitated: Intervene before agitation escalates. Review of the facility initial investigation, dated 11/29/23 at 7:11 P.M., showed: (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident #12 and Resident #11 were involved in an altercation this evening. Staff observed Resident #12 walk up to Resident #11 and strike him/her in the face. While Code Green (an emergency code, all available staff are to respond) was being called, Resident #11 hit Resident #12 back. Staff intervened and removed Resident #11 from the hall for safety and further assessment. Both residents received skin and pain and neuro assessments were within normal limits (WNL) and were sent to the hospital for evaluation and treatment. Residents will remain separated in the hall upon return to the facility from the hospital. Care plans updated to include this incident as well as Resident #12's tendency to become physical without warning. There was no warning of this incident. Residents have not had previous altercations with each other; -SUMMARY: The investigation yields Resident #11 struck Resident #12 because he/she was angry that Resident #12 was laughing at him/her. Resident #12 in turn hit Resident #11 back in the face in self-defense. Neither resident has returned from their respective hospitals since the incident. The IDT (interdisciplinary team) plans to place both residents on 1:1 monitoring, with Social Services to increase the weekly group to twice weekly. IDT to meet with these residents weekly to help identify coping strategies to assist residents with self-de-escalation. Both residents will be scheduled with psych upon their return to review labs and medication regime. Activities will meet with the residents daily and document twice weekly on progress for one month. The IDT will re-evaluate both residents within 30 days of return to the facility. Review of the Administrator/Registered Nurse Investigation, dated 11/30/23, showed; -Persons involved: Resident #11 and Resident #12; -Investigative Narrative Note: Resident #12 stated peer was teasing him/her about his/her heartburn. Resident stated he/she became angry and displayed physical aggression; -Conclusion: The staff person who was assigned to Resident #12 left on break. Staff member did not notify the nurse or wait for a replacement 1:1 to watch Resident #12 while the staff was on break. All staff were just educated on 1:1 and intensive monitoring. Employee was immediately suspended and was eventually terminated. During an interview on 12/7/23 at 1:50 P.M., Dietary Aide (DA) G said DA I was assigned to the 1:1 with Resident #12. DA I left the building with DA G to move DA I's car. DA I left his/her 1:1, Resident #12, with someone on the hall who said he/she would watch the resident. This was around 7:00 P.M. or 8:00 P.M. in the evening. During an interview on 12/7/23, at 3:06 P.M., DA H said DA I was assigned to the 1:1 with Resident #12. DA I said he/she was going on his/her 30 minute break. DA H said he/she was already assigned a 1:1 with a different resident and tried to keep an eye on Resident #12 too. He/She said Resident #12 used to be chill, but woke up and said to DA H, whoever you want me to mess up, I'll mess them up. DA H told the resident not to mess with anyone, but later a fight broke out. DA I left the hall and about 30 minutes later, the fight broke out. DA H said he/she tried to watch Resident #12, but he already was assigned a 1:1 with a different resident. (continued on next page)

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	265823	A. Building B. Wing	12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/8/23 at 2:05 P.M., the Regional Director said DA I had been educated two days earlier, within twenty-four hours had been in serviced on 1:1's, and chose to leave on break inappropriately, he/she still chose to not take his/her break appropriately. Staff are competent, have been educated and chose not to do what they were educated on and were terminated. MO00228114

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44950 Based on observation, interview and record review, the facility failed to ensure one resident (Resident #25) with a diagnosis of diabetes consistently received blood sugar level checks (measures the level of glucose (sugar) in the blood) and insulin administration. The facility failed to notify the physician of a blood sugar reading over 451, as ordered by the physician. On 12/23/23, the resident had a blood sugar level of 550. The resident was transferred to the hospital on 12/24/23 and diagnosed with diabetic ketoacidosis with coma associated with diabetes. The resident passed away on 12/25/23. Additionally, facility staff failed to clarify physician orders and obtain specific parameters for use when one resident (Resident #24) with a diagnosis of seizure disorder and a history of multiple seizures, was prescribed Valtoco (short-term treatment of seizure clusters), an as necessary (PRN) medication for seizures, and failed to consistently notify the resident's physician after every seizure. Last, staff failed to administer one resident's (Resident #23) medications as ordered and failed to document an explanation as to why the medications could not be administered on the medication administration record (MAR) and/or in the resident's progress notes. The sample size was 22. The census was 140. The administrator was informed on 2/5/24 of an Immediate Jeopardy (IJ), which began on 12/23/23. The IJ was removed on 2/6/24 as confirmed by surveyor on-site verification. Review of the facility's Blood Glucose Monitoring and Insulin Administration Policy, dated revised 6/29/23, showed: -Affected personnel: Registered Nurses (RN), Licensed Practical Nurses (LPN) and Certified Medication Technicians (CMT); -Purpose: To define accurate procedures to be followed when checking a blood sugar. To identify what measures will be taken in the event that a blood sugar falls out of the defined therapeutic range; -Procedure: If the resident's blood sugar is over 400, the physician will be notified by the charge nurse and orders will be followed. 1. Review of Resident #25's Admission Record, showed the resident was admitted to the facility on [DATE], with diagnoses that included diabetes (a chronic, metabolic disease characterized by elevated levels of blood glucose (blood sugar)). Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/10/23, showed: -Cognitively intact; -Had a diagnosis of diabetes; -Received insulin injections. Review of the resident's care plan, showed: (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Focus: At risk for alteration in health related to diabetes. Resident is on a regular low concentrated sweets diet (LCS, reduced carbohydrate diet) revised on 8/12/22; -Goal: The resident will have no complications related to diabetes through the review date, initiated on 12/11/21; -Interventions: Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness, initiated 12/11/21. Review of the resident's December 2023 Physician's Order Summary, showed: -Check and record blood sugar four times a day for diabetes, dated 8/17/23; -Dexcom G7 Receiver Device (Continuous Blood Glucose System Receiver). Inject 1 application intramuscularly one time a day related to diabetes, dated 8/17/23; -Dexcom G7 Sensor Miscellaneous (Continuous Blood Glucose System Sensor). Inject 1 application intramuscularly one time a day related to diabetes, dated 8/17/23; -Insulin Aspart FlexPen Subcutaneous Solution Pen injector (a short-acting insulin used to control blood sugar levels in the blood), 100 units per milliliter (ml). Inject subcutaneously (under all the layers of the skin) three times a day, as per sliding scale: --If blood sugar level is 200 - 250 = administer 3 units; --251 - 300 = 5 units; --301 - 350 = 7 units; --351 - 400 = 9 units; --401 - 450 = 11 units; --Over 451, Contact Physician, dated 10/31/23; -Lantus SoloStar Subcutaneous Solution Pen-injector (Insulin Glargine - a long-acting insulin used to control blood sugar levels in the blood), 100 units per ml. Inject 10 units subcutaneously every morning and at bedtime related to diabetes, dated 12/17/23. Review of the resident's December 2023 Accu check and insulin administration record, showed: -Lantus SoloStar Subcutaneous Solution Pen-injector 100 units per milliliter, inject 10 units subcutaneously every morning and at bedtime related to diabetes, dated 12/17/23, blank and not marked as provided on 12/9/23 at 7:00 P.M., and 12/17/23 at 7:00 P.M.; -Insulin Aspart FlexPen Subcutaneous Solution Pen injector 100 units per milliliter, inject subcutaneously three times a day, as per sliding scale: (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	--if blood sugar level is 200 - 250 = administer 3 units; --251 - 300 = 5 units; --301 - 350 = 7 units; --351 - 400 = 9 units; --401 - 450 = 11 units; --Over 451, contact physician; dated 10/31/23. Review of the resident's December 2023 Accu check and insulin administration record, showed: - on 12/13/23 at 6:00 P.M., facility staff did not document the resident's blood sugar level or if insulin injection was required; - on 12/17/23 at noon, facility staff did not document the resident's blood sugar level or if insulin injection was required; - on 12/19/23 at 6:00 P.M., facility staff did not document the resident's blood sugar level or if insulin injection was required. Review of the resident's Nursing Progress Notes, showed: -No documentation as to why there was no recorded administration of the regularly scheduled Lantus insulin on 12/9/23 at 7:00 P.M. and 12/17/23 at 7:00 P.M.; -No documentation to show why blood sugar level or administration of sliding scale insulin was not documented on 12/13/23 at 6:00 P.M., 12/17/23 at noon, and 12/19/23 at 6:00 P.M. Nurse Practitioner note date of service 12/21/23: --Blood sugar 426 on 12/21/23 at 11:55 A.M.; --Diagnoses: Brittle diabetes (hard to control) and Type 2 diabetes mellitus with hyperglycemia (spike in blood sugar levels); --Plan: patient is brittle diabetic. He/She is very sensitive to insulin. Medications reviewed. Last visit increased Lantus to 10 units BID (twice daily). Follow up routine visit and as needed; Review of the resident's December 2023 Accu check and insulin administration record, showed on 12/22/23 at 6:00 P.M., facility staff did not document the resident's blood sugar level or if insulin injection was required. Review of the resident's Nursing Progress Notes, showed no documentation to show why blood sugar level or administration of sliding scale insulin was not documented on 12/22/23 at 6:00 P.M (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the resident's December 2023 Accu check and insulin administration record, showed on 12/23/23 at 6:00 P.M., facility staff documented a blood sugar level of 550. The record showed sliding scale insulin was not administered on 12/23/23 at 6:00 P.M., due ot vitals outside of parameters for administration.The record did not include documentation the physician was notified of the blood sugar level of 550 or if any new orders were received. Review of the resident's Nursing Progress Notes, showed: -No documentation the physician was notified of the blood sugar level of 550 or if any new orders were received on 12/23/23 at 6:00 P.M.; -On 12/24/23 at 4:15 A.M, while doing routine rounds, the resident was breathing rapidly and lips were really dry. Vital signs were obtained: -temperature 96.4 (normal range between 97 F (Fahrenheit) and 99 F); -pulse 101- 105 (normal range 60 to 100 beats per minute); -respirations 32-28 (normal range from 12 to 16 breaths per minute); -blood pressure 87/52 (normal pressure is systolic (top number) of less than 120 and diastolic (bottom number) of less than 80 (120/80)); -blood sugar read HI >600. The nurse applied oxygen at 2 L (liter) per nasal cannula (a device that gives you additional oxygen through the nose); -12/24/23 at 4:31 A.M, call placed to resident's physician and reached the on-call physician. Made aware of what's going on with resident. Ok to send out 911. Resident is his/her own responsible party; -12/24/23 at 4:37 A.M., call placed to 911; -12/24/23 at 4:45 A.M.: Ambulance arrived at facility at 4:45 A.M.; -12/24/23 at 5:05 A.M.: Resident exited building with ambulance via stretcher. Review of the resident's Hospital Records, showed: -emergency room notes: --Chief complaint: hyperglycemia (elevated blood sugar level); (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	--Transfer to the emergency department by EMS due to hyperglycemia. EMS states the patient's blood glucose level has been reading in the 500's since 4:00 P.M. on 12/23/23. Upon arrival at the emergency department the patient was unresponsive to verbal stimuli. The patient does respond to painful stimuli. The patient is hypotensive (abnormally low blood pressure). The patient suddenly started vomiting and likely aspirated (inhaling saliva, food, liquid, vomit and even small foreign objects into the lungs). The patient has a history of diabetes and diabetic ketoacidosis (DKA - A serious diabetes complication where the body produces excess blood acids (ketones)); -Final diagnoses: --Aspiration pneumonia of both lungs; --Altered mental status; --Diabetic ketoacidosis with coma associated with diabetes; --Acute kidney injury. During an interview on 1/24/24 at 1:49 P.M., CMT Y said: -CMTs performed the accu checks and insulin administration; -The resident's blood sugar was taken before dinner and at bedtime; -His/Her blood sugar always ran high; -Every time his/her blood sugar would run low or high, he/she would notify the nurse and let the nurse make the final decision on if to contact the physician or not; -He/She did not know if the physician was notified on 12/23/23, but was sure it was out of range; -He/she always asked the nurse what to do before giving insulin; -He/she did not remember if the resident received any insulin on 12/23/23; -Looking at the administration record, he/she got the long-lasting insulin but not the sliding scale due to the nurse needing to contact the physician to get an order for the dose to be administered; -He/She did not remember who the nurse was but was sure he/she told the nurse. During an interview on 1/24/24 at 3:05 P.M., LPN X said: -He/She did not recall 12/23/23, and the resident's blood sugar being elevated; -The resident had a history of refusing insulin; -If the CMT had notified him/her of the elevated blood sugar he/she would have contacted the physician for new orders; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265823	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/08/2023
NAME OF PROVIDER OR SUPPLIER Crestwood Health Care Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 11400 Mehl Avenue Florissant, MO 63033	

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-He/She would normally make a note in the resident's progress notes any time he/she would contact the physician; -There should never be a blank on the administration record, there should always be some kind of documentation; -He/She expected the CMT to notify him/her immediately if there is a blood sugar level out of range. During an interview on 1/23/24 at 1:17 P.M., LPN A said: -CMTs performed the accu checks and administer insulin; -If the CMT was not certified, then the nurse would do it; -The CMT should notify the nurse immediately if the blood sugar level was not in range; -A blood sugar level of 550 was out of range and the nurse should be notified immediately; -The nurse would then reach out to the physician and put any new orders in place; -The CMT could not hold insulin due to the blood sugar level being out of range; -The MAR should be signed out when any medication was administered. During an interview on 1/25/24 at 10:17 A.M., Nurse K said: -The nurse/CMT should always record the accu check level and insulin administration; -If a blood sugar level was not obtained or insulin not administered, the expectation was to mark why; -CMTs were responsible for obtaining blood sugar levels and administering insulin; -He/She expected CMTs to notify him/her immediately if a blood sugar level was out of range; -A blood sugar level of 550 was out of range and needed to be called to the physician for new orders; -Any physician contact or new orders should be documented in the resident's chart. If a resident had a blood sugar out of parameters, he/she would call the physician, get an order for a one-time insulin administration, chart it, administer the insulin and the go back 20-30 minutes later to check on the resident, then document the follow up check. During an interview on 12/25/24 at 10:45 A.M., Nurse N said: -There should never be any blanks on the administration record, there were always options to pick from; (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-If it was blank, it was assumed it was not performed/administered; -Blood sugar levels and insulin administration were performed by the CMTs; -He/She expected the CMT to notify him/her immediately if a blood sugar level was out of range; -He/she would need to call the physician and get an order for insulin administration based on the blood sugar level; -A blood sugar level of 550 was out of range and required physician notification; -Any physician contact or new orders should always be documented in the resident's progress notes. During an interview on 1/25/24 at 12:57 P.M., the Director of Nursing (DON) said: -He/She expected staff to follow all physician orders; -He/She expected the MAR to be signed out when medication was administered, and that included blood sugar levels and insulin administration; -If there was a blank on the administration record, it meant the insulin was not administered; -The CMT must notify the nurse immediately if there was a blood sugar level out of range and the nurse would then notify the physician for new orders; -Any physician contact should be documented in the resident's progress notes; -Any new orders should be documented on the MAR and in the resident's progress notes; -If a blood sugar level was higher than the parameters, the nurse should go back and check on the resident in at least one hour and document the follow up; -He/She was going to change the process and give the blood sugar level checks and insulin administration tasks back to the nurses. 2. Review of Resident #24's annual MDS, dated [DATE], showed: -Makes Self Understood: Usually understood - difficulty communicating some words or finishing thoughts but is able if prompted or given time; -Ability to Understand Others: Understands, clear comprehension; -Diagnoses of seizure disorder or epilepsy (a brain disorder that causes recurring, unprovoked seizures), manic depression/bipolar disease (extreme mood swing) and schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves). (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the resident's diagnoses located in the resident's medical record, showed a diagnosis of epileptic seizures related to external causes, not intractable (difficult to manage/alleviate, keep under control) with status epilepticus (a seizure that lasts longer than 5 minutes, or having more than 1 seizure within a 5 minutes period, without returning to a normal level of consciousness between episodes). Review of the resident's care plan, initiated on 5/26/21 revised on 12/5/23, showed: -Focus: Risk for falls related to psychotropic drug (a drug that affects behavior, mood, thoughts, or perception) use, seizures, and head injury. Resident wears helmet for seizures. -Goal: Will be free from falls through review date; -Interventions: Anticipate and meet the resident's needs. To wear helmet while up. Review of the resident's physician's order sheet (POS), included the following orders: -Start Date: 9/11/23: Valtoco (diazepam (Valium)) benzodiazepine/anticonvulsant (a class of agents that work in the central nervous system) used to treat seizure clusters (seizures that occur in groups/clusters over a number of hours/days) 20 milligrams (mg) nasal liquid therapy pack 10 mg/0.1 milliliters (ml) (diazepam (anticonvulsant)), 0.2 ml in both nostrils every 4 hours PRN for seizures related to epileptic seizures. Discontinue Date: 12/14/23 (The order did not contain specific parameters for use- including if the medication should be administered after one seizure or more.); -Start Date: 12/17/23: Valtoco 20 mg dose nasal liquid therapy pack 10 mg)/0.1 ml, 0.2 ml in both nostrils every 4 hours PRN for seizure activity (The order did not contain specific parameters for use- including if the medication should be administered after one seizure or more.); -Start Date: 12/18/23: Lacosamide (Vimpat/anticonvulsant) 200 mg two times a day (BID) for anticonvulsant; -Start Date: 12/18/23: Valporic acid (used to treat various types of seizure disorders) 250 mg, two capsules (500 mg) BID anticonvulsant; -Start Date: 1/4/24: Levetiracetam (Keppra/anticonvulsant) 250 mg, five tablets (1250 mg) BID for epilepsy. Observation of the facility medication cart on 1/24/24 at 9:00 A.M., showed two boxes of Valtoco, each containing two spray devices. One box was sent to the facility from the pharmacy on 4/19/23, and contained one of two doses. The second box was sent to the facility from the pharmacy on 9/15/23, and contained two of two doses. Review of the Valtoco manufacturer's instructions found in the medication box received from the facility pharmacy, showed: (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Indications for usage: Valtoco is a benzodiazepine indicated for the acute (sudden/immediate) treatment of intermittent, stereotypic episodes of frequent seizure activity (i.e. seizure clusters, acute repetitive seizures) that are distinct from a patient's usual seizure pattern in patients with epilepsy six years of age and older; -How to use Valtoco: Use Valtoco exactly as prescribed by your healthcare prescriber; -Valtoco is given in the nose only. Valtoco comes ready to use. If needed a second dose may be given at least 4 hours after the first dose. Do not give more than two doses to treat a seizure cluster; -Instructions for use: Safely secure the person. If the person appears to be having a seizure, gently help them to the floor and lay them on their side in a place where they cannot fall. The person can be on either their side or back to receive Valtoco. One dose equals two nasal spray devices. Each device sprays one time only. After giving Valtoco keep or move the person onto their side, facing you, so that you can watch them closely. According to the Valtoco manufacturer's website, seizure clusters, are episodes of frequent seizure activity, that occur 2 or more times within a 24-hour period. Review of the resident's December 2023 progress notes, showed: -12/8/23 at 5:32 P.M., documented by Nurse B: It was brought to my attention as nurse that this resident had a seizure lasting 1 minute. Resident lowered to the floor by nursing staff. Resident shows no signs or symptoms of loss of consciousness upon cessation of seizure. Resident transferred off the floor with the help of two staff members, transferred to a wheelchair and propelled to room by staff. Call placed to physician. May transport to hospital for further evaluation. Emergency Medical Services (EMS) arrived and transported resident to hospital. Resident responding and respirations even and unlabored. Resident remains stable upon departure; -No documentation Valtoco nasal spray was administered; -12/8/23 at 10:30 P.M.: Resident returned from hospital with no new orders. Vimpat and Keppra order faxed to pharmacy for physician order update. Resident remains stable upon return; -12/12/23 at 6:38 P.M.: Resident walking down the hall and yelled out. Resident then fell , but did not hit his/her head. Resident had seizure activity noted for about 1 minute. Resident then stood up. Resident responding verbally, and denies complaints of pain. Resident placed at nurse's station for protective oversight. Physician notified; -No documentation Valtoco nasal spray was administered; -12/13/23 at 11:32 P.M.: This writer heard resident yell out as he/she did before he/she had a seizure. Before staff could get to resident he/she fell forward hitting his/her face on the floor. Blood noted to right side of face, his/her mouth and chin. Upon assessing he/she was noted to be alert and responding appropriately. 911 was called and resident was sent to hospital for an evaluation. Physician was notified. Resident returned to facility with no new orders; -No documentation Valtoco nasal spray was administered; (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-12/14/23 at 12:19 P.M., documented by Nurse K: Code blue called. Resident found unresponsive and actively having a seizure. Resident was bleeding from right upper lip and left lower chin. Resident actively seized for 5 minutes. Oxygen saturation ranged from 93%-97% (normal range 95%-100%) until EMS arrived. Resident's eyes were not equal or accommodating to light during this period. Resident sent to hospital to receive care. Physician notified; -No documentation Valtoco nasal spray was administered; -12/17/23 at 2:34 P.M.: Resident started on Valporic Acid and stopped Briviact (anticonvulsant). Resident saw neurologist and suggested follow-up on 1/3/23; -12/29/23 at 6:00 A.M.: Resident observed to be displaying seizure activity while seated in a chair. Area made safe for resident for the duration of seizure activity lasting approximately 1 minute. When activity discontinued resident made comfortable and allowed to rest. Resident remains on intensive monitoring for protective oversight; -No documentation the resident's physician was notified; -No documentation Valtoco nasal spray was administered; -12/29/23 at 9:18 A.M., documented by Nurse K: Resident observed to be displaying seizure activity while sitting on bed. Area made safe for resident for the duration of seizure activity lasting approximately 1 minute. When activity discontinued resident made comfortable and allowed to rest. Resident remains on intensive monitoring for protective oversight. Morning medications given. No seizure activity since then; -No documentation the resident's physician was notified; -No documentation Valtoco nasal spray was administered. Review of the resident's MAR, dated 12/1/23 through 12/31/23, showed: -Valtoco 20 mg one spray in both nostrils every 4 hours as needed for seizures related to epileptic seizures; -No initials showed staff administered the Valtoco the entire month of December. Review of the resident's January 2024 progress notes, showed: (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-1/3/24 at 9:00 A.M.: Certified Nursing Assistant (CNA) approached nurse station at this time propelling resident in wheelchair making this nurse aware resident appeared to have had change in condition while sitting at dining room table during breakfast. Immediately assessed resident noted with head down, calling name with no response, noted rise and fall of chest with eyes open and spontaneous jerking noted. This nurse and CNA assisted resident to room and in bed safely as resident unable to sit up in wheelchair. During assessment resident noted to stare off and to begin spontaneous jerking with no response when nurse called out during assessment. Episode lasted about 30 seconds and resident began to respond when name called. Call to 911 to make aware of needed transport for emergent evaluation. Call placed to physician. Ambulance arrived to facility, resident remained awake with Registered Nurse Supervisor at bedside noting one seizure episode since this nurse left bedside. Resident left facility at that time via ambulance; -No documentation Valtoco nasal spray was administered; -1/3/24 at 9:30 A.M., documented by Nurse B: This nurse summoned to dining room regarding this resident, upon entering the dining room this nurse noted resident sitting in chair at table lethargic and responding little to verbal stimuli. This nurse asked resident how he/she felt, the resident dropped his/her head and did not respond. Rise and fall of chest noted evenly, resident's vital signs and oxygen saturation within normal limits. Call placed to physician with new orders to send to the hospital for further evaluation. EMS arrived and transferred resident to hospital for further evaluation. Resident had neurologist appointment scheduled this shift. Neurologist appointment postponed until a further day; -No documentation Valtoco nasal spray was administered; -1/3/24 at 5:33 P.M., documented by Nurse B: Resident returned from hospital with new orders to increase Keppra to 1,250 mg two times a day. MAR updated, resident remained stable upon return; -1/14/24 at 12:33 P.M., documented by Nurse K: Resident found in hallway having a seizure. Seizure lasted approximately three minutes. Helmet was in place at the time of the incident. No injury noted. Physician notified, said to monitor; -No documentation Valtoco nasal spray was administered; -1/15/24 at 1:03 A.M.: Resident had seizure activity this evening of inexact length of time. The seizure activity happened from the time the resident's roommate went to the dining room to heat ramen noodles for resident and returned back to the room. Upon entering this writer observed resident lying crosswise on bed, his/her body was stiff and rigid and he/she was making a loud snoring noise. This activity lasted approximately 1.5 minutes before seizure activity was over. This writer verified with CMT resident's medications required for seizure activity; -No documentation the resident's physician was notified. -No documentation Valtoco nasal spray was administered; (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-1/15/24 at 5:54 A.M.: While on 600 hall passing medication, was called to resident's room by his/her roommate saying the resident was having a seizure. Writer was two doors away and as writer got to the resident's room the seizure activity was stopping and resident was coming out of it. Seizure lasted 30-50 seconds (estimated). Will continue to monitor; -No documentation the physician was notified. -No documentation Valtoco nasal spray was administered; -1/15/24 at 9:25 A.M., documented by Nurse K: Resident found in hallway having a seizure at 7:00 A.M. medication pass. Seizure lasted approximately 3 minutes. Helmet was in place at time of incident. No injury noted. Physician notified and made aware of multiple occurrences since 1/14/24. Physician stated to monitor and the next occurrence send the resident out; -No documentation Valtoco nasal spray was administered; -1/15/24 at 11:13 A.M., documented by Nurse K: Diazapam was administered in left nostril during seizure. Review of the resident's medication signature sign out sheet, showed one dose of Valtoco was administered on 1/15/24. Review of the resident's MAR, dated 1/1/24 through 1/31/24, showed: -Valtoco 20 mg one spray in both nostrils every 4 hours as needed for seizures related to epileptic seizures; -No documentation staff administered the Valtoco on 1/15/24. During an interview on 1/24/24 at 8:32 A.M., Nurse K said he/she had worked at the facility for about three years. The resident had a lot of seizures. He/She had not given the resident Valtoco nasal spray. He/She did not think the resident had had an order for the medication too long. CMTs could not administer Valtoco, only nurses. The medication should have been given when the resident had a seizure. Nurse K had not received any previous directives to not administer the medication when the resident had a seizure. He/She was present on 1/15/23, when the resident had a seizure and Nurse B administered the medication. He/She did not know why Nurse B did not initial the medication had been administered as given on the MAR on 1/15/24. Nurses are responsible to initial a medication was administered on the MAR for any medication administered. During an interview on 1/24/24 at 8:57 A.M., Nurse B said he/she had worked at the facility for about four months. Only nurses were allowed to administer Valtoco. He/She administered the Valtoco on 1/15/24 because the resident had a seizure. Even though the resident had had several seizures, that was the first time he/she had administered the Valtoco. He/She was not sure why he/she had not administered the Valtoco prior to 1/15/24. If a medication was administered, it should be initialed as given. If a medication can't be administered there should be an explanation as to why either on the MAR or in the progress notes. He/She should have initialed the medication on 1/15/24. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 1/24/24 at 10:31 A.M., the resident's physician said she did not order the Valtoco. She said the resident's neurologist ordered the medication. She would expect staff to administer the Valtoco as ordered and/or per the manufacturer's guidelines. During an interview on 1/25/24 at 1:00 P.M., the DON said she expected staff to administer any medication including Valtoco per the physician's orders. Any medication administered should be initialed as administered on the MAR. If a medication cannot be administered, she expected staff to document a reason why on the MAR or in the progress notes. 3. Review of Resident 23's quarterly MDS, dated [DATE], showed: -Speech Clarity: Clear speech, distinct intelligible words; -Makes Self Understood: Understood; -Ability to Understand Others: Understands; -Diagnoses of high blood pressure, diabetes mellitus (DM), hyperlipidemia (high cholesterol/elevated levels of lipids (fatty compounds) in the blood), anxiety, depression, manic depression/bipolar disease and schizophrenia. Review of the resident's care plan, last revised on 2/14/22, showed: -Focus: History of behavioral challenges; -Goal: Resident will have no serious injuries due to behaviors; -Interventions: Pharmaceutical interventions as needed. Administer medications as ordered; -Focus: Potential to be verbally/physically aggressive related to diagnosis of schizophrenia; -Goal: Will not harm self or others; -Interventions: Administer medications as ordered; -Focus: At risk for impaired cognitive (thought) function due to schizophrenia, bipolar depression and anxiety; -Goal: Will remain at current level of cognitive function; -Interventions: Administer medications as ordered; -Focus: At risk for alteration in health and hyperglycemic (high)/hypoglycemic (low) episodes related to DM; -Goal: Will have no complications related to DM; -Interventions: Diabetes medications as ordered by physician. Glucose monitoring; (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Focus: At risk for adverse reactions related to psychotropic medications due to major depression and schizophrenia; -Goal: Will remain free of psychotropic drug related complications; -Interventions: Administer psychotropic medications as ordered by the physician; -Focus: At risk for alteration in neurological status related to diagnosis of restless leg syndrome; -Goal: Will remain with optimal status and quality of life within limitations imposed by neurological deficits; -Interventions: Give medications as ordered. Review of the resident's POS, showed the following orders: -No Start Date: Blood glucose before breakfast in the morning for DM; -Start Date: 2/14/22: Benztropine 1 mg, 1 tablet daily at 7:00 A.M., 12:00 P.M., and 6:00 P.M. related to schizophrenia; -Start Date: 2/14/22: Buspirone 10 mg, 1 tablet daily at 7:00 A.M., 12:00 P.M., and 6:00 P.M. related to paranoid schizophrenia; -Start Date: 2/17/22: Fluphenazine 10 mg, 1 tablet daily at 7:00 A.M., 12:00 P.M., and 6:00 P.M. related to schizophrenia; -Start Date: 2/14/22: Risperidone 2 mg, 1 tablet daily at 7:00 A.M., 12:00 P.M., and 6:00 P.M. related to unspecified psychosis (an acute or chronic mental state marked by loss of contact with reality); -Start Date: 7/26/22: Topiramate 100 mg, 1 tablet daily at 7:00 A.M., 12:00 P.M., and 6:00 P.M. related to schizophrenia; -Start Date: 7/14/23: Atorvastatin 40 mg, 1 tablet at 6:00 P.M. for high cholesterol; -Start Date: 7/14/23: Mirtazapine 15 mg, 1 tablet daily at 6:00 P.M. for anxiety; -Start Date: 7/14/23: Pramipexole 0.5 mg, 1 tablet at 6:00 P.M. for restless leg syndrome (a long-term disorder that causes a strong urge to move one's legs); -Start Date: 7/14/23: Trazodone 100 mg, 1 tablet at 6:00 P.M. for insomnia (difficult falling asleep); -Start Date: 8/25/23: Metfor