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	01/10/2024

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 - Minimal harm or potential for actual harm 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** 40291 Based on interview and record review, the facility failed to ensure a resident's right to be free from abuse was not violated, when residents were abused by other residents (Resident #1, #2, #3, and #4) for four of five sampled residents. The facility census was 136 residents. The Administrator was notified on 1/10/24 of the past non-compliance. The facility immediately began investigations of the incidents, separated and assessed the residents, as well as contacted all responsible parties and physicians, and sent the residents out for evaluations following the altercations. Upon the residents' return to the facility, the facility had interventions in place to ensure no further altercations would take place, which included: Medication adjustments (while at the hospital), room changes, frequent meetings, and social services follow up. In addition, abuse and neglect inservicing had been completed with staff, which included resident to resident abuse. The noncompliance was corrected on 12/23/23. Review of the facility's Abuse and Neglect policy, revised 1/5/23, showed: -Physical abuse: Beating, striking, wounding, or injuring any resident or any manner whatsoever mistreating, or maltreating a resident in a brutal or inhumane manner. Physical abuse also includes, but is not limited to hitting, slapping, punching, biting and kicking. -Verbal abuse: Using profanity or speaking in a demeaning, non-therapeutic undignified, threatening or derogatory manner in a resident's presence. Examples include harassing a resident; mocking, insulting, ridiculing, yelling at a resident with the intent to intimidate; threatening residents; -Mistreatment, abuse, or neglect; -Mistreatment, abuse, or neglect 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 individuals, and family members, legal guardians, friends, or any other individual. (continued on next page)

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

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Review of the Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/17/23, showed: -Intact cognition; -No behaviors; -Diagnoses included peripheral vascular disease (PVD, poor circulation), depression and manic depression. Review of the resident's progress notes, dated 12/22/23, showed: -At 3:51 P.M., the resident had a physical altercation with another resident. They had a few words, and they threw food trays at one another. No injuries noted; -At 4:00 P.M., a code green (all call for help. all staff assist) was called due to a resident-to-resident altercation. Resident #1 threw a food tray at Resident #2, and in return he/she struck Resident #1 with a closed fist to the left side of his/her face. The guardian was contacted. Voicemail was left. Resident #1 was removed from the hall and met with the Social Service Director (SSD); -At 6:08 P.M., skin note: Slight bruising noted; not able to distinguish shape as of yet. Injury occurred as a result of a tray thrown at the resident. Resident #1 was sent to the local area hospital for evaluation. Review of the resident's care plan, dated 12/23/23, showed: -Focus: 12/23/23 update: The resident was involved in an altercation with his/her peer. The resident went to the peer's room to visit with his/her roommate when the peer became upset with the resident and cursed at him/her. The resident in turn, threw a food tray at the peer which did not strike him/her. The peer then struck the resident in the face. Staff separated them and completed an assessment. No injury to either party; -Goal: The resident will not cause serious injury to self or others now through next review date; -Interventions: Guardian, physician, and the police notified; New order received for as needed (PRN), which was not needed. Assessment completed without injury. Sent to the hospital for further assessment. Room moved off unit. 2. Review of the Resident #2's quarterly MDS, dated [DATE], showed: -Severely impaired cognition; -No behaviors; -Diagnoses included anemia, heart failure, high blood pressure, end stage renal disease (ESRD, chronic irreversible kidney failure), diabetes, schizophrenia (a mental condition that causes both psychosis (a loss of contact with reality) and mood problems), depression, and chronic obstructive pulmonary disease (COPD, lung disease). (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's progress notes, dated 12/22/23 at 5:11 P.M., showed a code green was called due to a resident-to-resident altercation. Resident #1 entered the room of Resident #2 and threw a food tray at him/her. In return, Resident #2 struck Resident #1 on the left side of his/her face with a closed fist. Resident #2 was sent to the hospital for an evaluation. The guardian was contacted. Review of the resident's care plan, dated 12/23/23, showed: -Focus: The resident was involved in an altercation with his/her peer. The resident's peer went into the resident's room to visit with the resident's roommate and the resident became upset and started cursing at his/her peer. The resident's peer threw a food tray at the resident which in turn, the resident struck his/her peer in the face. Both residents were separated and assessed without injury; -Goal: The resident will not harm him/herself or others through next review date; -Interventions: The guardian, physician, and police were notified. The resident was separated from his/her peer. Gave him/her PRN and sent to the hospital. 3. Review of the facility's investigation, dated 12/24/23, showed: -Investigative narrative note: Resident #1 entered the room of Resident #2 to visit Resident #2's roommate. Resident #2 became agitated on that day and a physical altercation occurred. Resident #1 says a famous boxer is his/her father, and Resident #2 was making fun of Resident #1 for believing that. Resident #1 picked up a dinner tray and threw it at Resident #2, missing him/her. Resident #2 then stood up and punched Resident #1 in the face with a closed fist. Hall Monitor (HM) A was passing by the room and immediately separated the residents and called a code green, There was a slight redness noted on Resident #1's right jaw, but no swelling. Both residents had intact skin. Resident #1 denied pain and was able to move his/her jaw without difficulty. PRN orders obtained as well as orders to send to the emergency department (ED). Messages left with guardian per SSD. Law enforcement notified. Department of Health of Senior Services self report completed. Director of Nurses (DON), Administrator, management also notified. Both residents sent to ED and returned within a few hours with no new orders. Rooms changes were made, and Resident #1 placed on one-to-one monitoring upon return from ED; -Conclusion: The investigation incident was an isolated occurrence. Resident #2 is non-compliant and does not take his/her medication. Providers in hospice are aware he/she is non-complaint with care. Resident #2 has a history of aggression towards peers and staff as well as false allegations. Resident #1 can be intrusive and has poor awareness of personal space/boundaries and has delusions of being [NAME] and has intellectual disabilities; -Care plans/interventions: Residents separated. Assessed head to toe. Obtained orders for PRNs. Resident #2 moved from hall where Resident #1 resided. Both residents sent to ED for evaluation and returned shortly after with no new orders. Resident #1 was placed on a different hall with one-to-one monitoring. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/3/24 at 1:06 P.M., Resident #1 said he/she was familiar with Resident #2. They had an altercation. He/She had issues with Resident #2 because Resident #2 called him/her out of his/her name and hit Resident #1 in his/her jaw. Resident #1 didn't want to hurt Resident #2, so he/she didn't hit Resident #2 back. Resident #2 called Resident #1 out of his/her name because Resident #1 told Resident #2's roommate that Resident #2 was stealing his/her roommate's sodas. The staff did break the incident up. During an interview on 1/3/24 at 4:02 P.M., Resident #2 denied Resident #1 hit him/her, and Resident #2 denied hitting Resident #1. He/She said Resident #1 was joking with him/her. During an interview on 1/3/24 at 2:30 P.M., HM A said Residents #1 and #2 did have a resident to resident altercation. HM A was on the hall on a one-to-one with another resident when Resident #1 came down the hall. HM A heard Resident #1 enter the room talking to the other resident in the room. HM A then heard commotion coming from the room, so he/she walked toward the room. As he/she got closer to the room, Resident #1 threw a food tray at Resident #2, so HM A called a code green. As HM A entered the room, Resident #1 was backing out of the room. HM A stood between Resident # 1 and Resident #2. As HM A was walking Resident #1 out the room, Resident # 2 reached over HM A and hit Resident #1. Resident #2 was in a wheelchair. Resident #2 stood up from his/her wheelchair and hit Resident #1 over HM A's shoulder. Other staff came and assisted. Both residents were separated. HM A was not for sure what led to the altercation or anything. He/She saw Resident #1 throw the tray and hit Resident #2 but did not know what had happened before then. That was the first incident that both residents have had with each other, and neither resident been aggressive with other people, as far as HM A was aware. 4. Review of the Resident #3's medical record, showed: -admitted : 12/21/23; -Intact cognition; -Diagnoses included Alzheimer's disease, anxiety, depression, manic depression (bipolar disorder, a mental illness that causes unusual shifts in a person's mood, energy, activity levels and concentration), psychotic disorder, and schizophrenia. Review of the Resident #3's progress notes, dated 12/23/23, showed: -At 5:10 P.M., staff responded to a code green being called on the 300 hall. Staff responded immediately. Resident #3 noted to be involved in a physical altercation with his/her peer. Resident #3 was allowed to vent his/her feelings and frustrations that led to that occurrence. The resident stated a verbal altercation started with Resident #4. Resident #3 stated that Resident #4 called him/her a racial slur and attempted to hit him/her with a chair. Resident #4 noted to have delusional thoughts. Complete head to toe assessment performed by Nurse C, no injuries noted at that time. Nurse Practitioner (NP) D made aware, new order to send to the hospital for evaluation and treatment. Upper management made aware. Message left for guardian. Resident requested to go to the local area hospital. Report called to Registered Nurse (RN) E. Staff to continue to monitor for protective oversight; (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-At approximately 6:00 P.M. (same incident as above but different entry), Resident #4 entered into the day room on the 300 hall. Once entered, Resident #3 and Resident #4 began to exchange profanity language toward each other. Resident #4 then picked up a chair and attempted to hit Resident #3 with it, staff intervened, removing the chair from Resident #4's hands. Both residents were separated. The charge curse contacted guardians. Voice mails were left. Law Enforcement informed of the incident. Self-report was completed within the two hour window. Resident #3 was taken to area local hospital via ambulance. Review of the resident's care plan, dated 12/24/23, showed: -Focus: Resident #3 was involved in an altercation with Resident #4. The incident was witnessed by staff. Resident #3 was sitting in the common room when Resident #4 entered and started cursing and accusing Resident #3 of calling his/her family member foul names. Resident #4 picked up a chair and attempted to swing it at Resident #3. Staff intervened, taking the chair, and then both residents started hitting each other open handed. Resident #3 pulled Resident #4's hair and then scratched him/her on the neck. The Residents were separated; -Goal: The resident will not cause serious injury to him/herself or others through next review; -Intervention: Resident #3 was separated from Resident #4 and an assessment was completed. The Administrator, guardian, physician, state agency, and the police were notified. Resident #3 was sent to the hospital for further assessment. He/She was placed on one-to-one for protective oversight. Social Services to follow up for 72 hours. 5. Review of the Resident #4's quarterly MDS, dated [DATE], showed: -Intact cognition; -No behaviors; -Diagnoses included epilepsy (seizure disorder), anxiety, depression, and schizophrenia. Review of the Resident #4's progress notes, dated 12/23/23 at 6:15 P.M., showed staff responded to a code green being called on the 300 hall. Staff responded immediately. Resident #4 noted to be involved in physical altercation with Resident #3. Resident #4 was allowed to vent his/her feelings and frustrations that led to that occurrence. Call was placed to NP D. New order for Zyprexa (anti-psychotic medication) every eight hours times fourteen days. Zyprexa injection administered in left deltoid. No adverse reactions noted. Upper management made aware. Message left for guardian. Staff to continue to monitor for protective oversight. Review of the resident's care plan, dated 12/24/23, showed: -Focus: Resident #4 was in the day room on his/her hall and told Resident #3 to shut the fuck up. They then got into a verbal altercation. Resident #4 picked up a chair and attempted to hit Resident #3. Staff intervened and removed the chair. As staff were removing the chair, Resident #4 and Resident #3 started swinging at each other, open handed. Resident #3 pulled Resident #4's hair and scratched him/her. Staff were able to separate the residents, and Resident #4 was placed at the nurse's station for protective oversight; (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Goal: Resident #4 will continue to receive protective oversight; -Interventions: The physician, psychiatrist, and guardian were notified. The local police department was notified and responded. Resident #3 was placed on one-to-one monitoring. New order for PRN Zyprexa Intramuscular (IM) for aggression and agitation. SSD to follow up with resident for 72 hours. Interdisciplinary team (IDT) to meet with Resident #4 weekly to discuss positive coping mechanisms. Psychiatric services to assess medications for a possible medication review. 6. Review of the facility's investigation, dated 12/23/23, showed: -Investigative narrative note: On 12/23/23 at approximately. 6:00 P.M., Resident #4 entered the day room on the 300 hall. Then both of the residents began to exchange profanity to each other. Resident #4 then picked up a chair and attempted to hit Resident #3 with it. Staff intervened and removed the chair from Resident #4. Both residents began to swing with open hands. Resident #3 then pulled Resident #4's hair and began to slap him/her. Both residents were separated. A PRN administered to Resident #4, and he/she was taken to the nurse's station for protective oversight. The charge nurse contacted the guardians and voice mails were left. Law enforcement was informed of the incident. The self-report was completed within the two hour window. The interventions included Resident #4 moved to the nurse's station for protective oversight, which allowed both residents to be separated. Resident #3 was sent to a local hospital; -Conclusion: Resident #3 was new to the facility and had been there only a couple of days. The resident was very aggressive but could be due to sudden placement in a new environment in which he/she was not familiar; -Care plan changes and interventions: Both residents remained in the hospital at the time. Upon arrival from hospital, they will be placed on one-to-one monitoring until assessed for behaviors. Ensure medication is in facility prior to arrival so that no medication doses are missed. Follow up with the physician for both residents. Social services to complete follow up for both residents. During an interview on 1/3/24 at 3:00 P.M., Hall Monitor B said Residents #3 and #4 had a resident-to-resident altercation about a week or two ago. Resident #3 was sitting in the TV area talking to other residents and music was playing. Resident #4 was in his/her room but walked down to the TV room. Resident #4 looked to the left and then to the right, and then said to Resident #3 Would you shut the fuck up? Resident #3 asked Resident #4 who was he/she talking to. Resident #4 replied, You, bitch. Resident #4 then asked Resident #3 if he/she wanted a punch. Resident #3 said You're not going to hit me. Resident #4 then proceeded to pick up a chair and turned to Resident #3 like he/she was going to hit Resident #3 with it but didn't. Resident #3 stood up and told Resident #4 that he/she was trying to hurt Resident #3, and he/she did not do anything to Resident #4. A code green was called. In the midst of that, Resident #3 pulled Resident's #4's hair and scratched him/her. There were no punches and/or no fists balled. There was just a lot of grabbing, trying to get to each other. HM B was in the middle of the residents. The chair was never swung. Both residents were sent out to the hospital at that time. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7. During an interview on 1/12/24 at 2:46 PM, the Administrator said Residents #1 and #2 are now both on separate halls to limit further contact. At times, Resident #1 could be protective of other people's stuff. When Resident #2 returned to the facility, he/she was just happy to be back and had forgotten all about the incident. Resident #2 had been to the Administrator's office every day since he/she returned. The Administrator meets with Resident #2 on a weekly basis. Regarding Residents #3 and #4, Resident #4 has returned back to the facility and is fine. Resident #3 is still out. The interventions in place include both residents being on opposite ends of the 300 hall. Regarding Resident #4, they did some medication adjustments and the Administrator has met with him/her three times since he/she has returned. The facility purchased Resident #4 some headphones, so he/she could drown out stuff around him/her. Resident #3 was new to the facility. Resident # 3 had no injuries. Resident #4 did have some superficial scratches to the left cheek and neck area. When a resident to resident altercation happens, staff put interventions into place at that time. Staff update the care plans when something happens and as needed. It was his expectation that all residents should be free from abuse and neglect. It was everyone's responsibility to ensure that all residents remain free from abuse and neglect. MO00229204 MO00229223