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	09/23/2024

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** 46970 Based on interview and record review, the facility failed to ensure a resident's right to be free from abuse was not violated, when staff failed to effectively intervene while two residents (Resident #1 and Resident #2) were involved in a verbal argument which escalated to a physical altercation, resulting in Resident #1 to be struck in the face by Resident #2. The facility census was 139. Review of the facility's Abuse and Neglect policy, revised 6/12/24, showed: -Definitions: -Abuse: The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology; -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 uses as a means to correct or control behavior; -Policy Guidelines: -Prevention: The facility will identify, correct and intervene in situations in which abuse, neglect and/or misappropriation of resident property is more likely to occur; -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. Review of the facility's Behavioral Emergency policy, revised 6/26/24, showed: (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	-Purpose: To provide safe treatment and humane care to the Resident in a behavioral crisis, to outline steps to follow to correctly care for the Resident in a behavioral crisis, to ensure that the resident is not being coerced, punished, or disciplined for staff convenience; -Interventions: Non-Physical and Proactive: -Non-physical interventions are the first choice as an intervention unless safety issues demand immediate physical intervention. The facility's approved early intervention crisis prevention techniques will be used to de-escalate conflict when possible. Care will be guided by resident's plan of care and based on the strategies taught by Crisis Prevention Institute non-violent crisis intervention, or the current company guidance, and will help to respond to difficult behaviors in the safest and most effective way possible; -Proactive management for our residents is the best plan. All staff should recognize when the resident has become or can become a danger to themselves or someone else. De-escalation techniques should be utilized as first resort. 1. Review of the facility's investigation, completed on 9/20/24, showed: -On 9/19/24 at 6:30 P.M., staff responded to Code [NAME] (emergency) being called on 300 hall. Resident #2 noted to be involved in physical altercation with Resident #1. Residents separated and were allowed to vent feelings and frustrations that led to this occurrence; -Resident #2 said One of his/her peers was having a bad day and Resident #1 wouldn't leave him/her alone. So the peer went to his/her room and Resident #2 stood outside the door. Resident #1 wouldn't leave the peer alone. He/She told Resident #1 numerous times to leave the peer alone. He/She then yelled numerous times and told Resident #1 to get out of his/her ears and he/she just slapped him/her. Resident #2 did not think he/she hit Resident #1 but he/she blacked out; -Resident #1 said Resident #2 got mad at him/her because he/she was trying to talk to a peer. Resident #2 started yelling at him/her, so he/she yelled back and Resident #2 punched him/her in his/her face; -Certified Nurse Assistant (CNA) A stated Resident #2 and Resident #1 were at the end of the hall when Resident #2 was trying to stop Resident #1 from going in another resident's room. He/She called for them to go back to their rooms when Resident #1 said something to Resident #2, that's when Resident #2 hit Resident #1 in his/her face; -Conclusion: Allegation is substantiated. Resident #1 was returned from the emergency room with no new orders. Resident #2 remains in the hospital at this time. 2. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 9/4/24, showed: -Cognitively intact; -No behaviors exhibited; (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses included anxiety disorder (intense, excessive, and persistent worry and fear about everyday situations) seizure disorder or epilepsy (uncontrolled jerking, loss of consciousness, blank stares. Or other symptoms caused by abnormal electrical activity in the brain), and schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly). Review of the resident's care plan, date initiated 5/5/21, showed: -Problem: The resident is at risk for injury to self and others related to being physically aggressive related to poor impulse control. He/She has a history of being combative; -Interventions included: -When the resident becomes agitated: Intervene before agitation escalates; -Guide away from source of distress; -Engage calmly in conversation. If response is aggressive, staff to walk calmly away and approach later. Review of the resident's medical records, showed: -An incident note dated 9/19/24 at 6:30 P.M., staff responded to Code [NAME] being called on the hall. Resident (Resident #1) noted to be involved in physical altercation with another resident (Resident #2). Residents separated and were allowed to vent feelings and frustrations that led to this occurrence. Resident states peer (Resident #2) became upset with him/her because the peer (Resident #2) did not want the resident (Resident #1) talking to another peer on the hall, they (Resident #1 and #2) had a verbal exchange and peer (Resident #2) hit him/her (Resident #1) in the face. No noted injuries. Resident placed on 1:1 at this time. Administrator, Director of Nursing (DON), MD (medical doctor), and guardian aware. Resident sent out to the hospital for evaluation and treatment via stretcher times two emergency medical system (EMS). Police Officer at the facility. Report called to hospital intake. Staff will continue to monitor for protective oversight; -A note dated 9/20/24 at 1:16 A.M., Resident returned from the hospital at 11:50 P.M. During an interview on 9/23/24 at 11:18 A.M., Resident #1 said Resident #2 got mad at him/her for wanting to talk to another resident. Resident #2 started yelling at him/her so he/she started yelling back and Resident#2 hit him/her in the face. He/She said Resident #2 hit him/her on the left side of his/her face and chest. He/She was still hurting a little bit in the chest where he/she got hit. He/She said Resident #2 punched him/her one time but the one time got him/her in both those places. After Resident #2 hit him/her, he/she backed up because the resident did not want to hit him/her back. Resident #1 said he/she didn't hit Resident #2 back because he/she didn't want to go on restriction, but they put him/her on a hall restriction anyway. 2. Review of Resident #2's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Mood disorder due to known physiological condition, unspecified; (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Physical behavioral symptoms directed toward others (e.g. hitting, kicking, pushing, scratching, grabbing, abusing others sexually) - behavior of this type occurred 1 to 3 days. Review of the resident's care plan, date initiated 4/8/24, showed: -Problem: Resident has potential to be verbally/physically aggressive related to diagnosis of ADHD predominately hyperactive type (a chronic mental disorder that affects a person's development and ability to function), mood disorder (a mental health condition that affects a person's emotional state. It's a disorder in which you experience long periods of extreme happiness, extreme sadness, or both. Certain mood disorders involve other persistent emotions, such as anger and irritability) due to known psychological condition, borderline personality disorder (a mental health condition that causes people to have long term patterns of unstable emotions), conduct disorder, nightmare disorder, and insomnia; -Interventions included: -When the resident becomes agitated: Intervene before agitation escalates; -Guide away from source of distress; -Engage calmly in conversation. If response is aggressive, staff to walk calmly away and approach later; -Care plan date initiated 7/1/24, showed, on 6/30/24, the resident was involved in an altercation with his/her peer. The resident came to his/her peer and was arguing about the bathroom. His/Her peer yelled a racial slur at the resident and the resident struck the peer multiple times in the head with a closed fist; -Intervention included: -Staff was present and called Code Green. Staff responded immediately to separated the residents. Skin assessment completed and no injuries noted. MD and guardian notified. The resident was sent to the emergency room for a psychological and medical evaluation. Upon return back to the facility, he/she will start on 1:1 monitoring until deemed safe to remove. Both residents required a locked unit but will remain separated on the hall. He/She will meet with the Interdisciplinary Team weekly to work on coping mechanisms and triggers. Review of the resident's medical record, showed: (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-An incident note, dated 9/19/24 at 6:30 P.M., staff responded to Code [NAME] being called on the hall. Resident (Resident's #1 and #2) noted to be involved in physical altercation with another resident. Resident separated and allowed to vent feelings and frustrations that led to this occurrence. Resident states he/she became upset with Resident #1 because he/she did not want the peer (Resident #1) talking to another peer on hall. They (Resident #1 and #2) had a verbal exchange and he/she (Resident #2) hit peer (Resident #1) in the face. Complete head to toe assessment performed, no noted injuries. Resident refused vital signs. He/She was placed on 1:1 at this time. Administrator, DON, MD, and guardian aware. Resident sent out to the hospital for evaluation and treatment via stretcher times two EMS. Police Officer at the facility. Report called to hospital intake. Staff will continue to monitor for protective oversight; -A progress note, dated 9/20/24 at 9:42 A.M., contacted the hospital and spoke with nurse to ensue/inform, they are aware of the resident being a high elopement risk. Nurse stated that he/she understood and was well aware and that the resident would be admitted . 4. During a telephone interview on 9/23/24 at 11:44 A.M., CNA A said Resident #2 was trying to keep Resident #1 out of another resident's room. CNA A said he/she couldn't hear what was being said but could tell Resident #1 and Resident #2 were going back and forth. When he/she realized that, he/she yelled for them to go to their rooms but before he/she could get them to their rooms, Resident #1 said something to Resident #2 but he/she could hear what was said. That's when Resident #2 hit Resident #1 in the face. Resident #1 never hit Resident #2 back, he/she just walked away. CNA A said he/she had abuse and de-escalation training. During an interview on 9/23/24 at 10:52 A.M., CNA B said they try to de-escalate residents before aggressive behavior got started and monitor behaviors to make sure there were no changes in behaviors. He/She would let the nurse know of changes before the resident escalated. They have walkie talkies to call Code [NAME] if a resident had behaviors. He/She had abuse training on how to properly perform a restraint. During an interview on 9/23/24 at 3:50 P.M., the DON said the hall where the resident's lived was a short hall. She thought CNA A yelling down the hall to the residents was ok because the hall was so short. During an interview on 9/23/24 at 2:41 P.M., the Administrator said the facility's surveillance video didn't go back past 72 hours, but she had watched the video. She said it just looked like Resident #2 was the aggressor. She expected CNA A to have gone down and checked on Resident #1 and Resident #2 instead of yelling down the hall for them to go back to his/her rooms. MO00242362