

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  12/20/2024
NAME OF PROVIDER OR SUPPLIER  Crestwood Health Care Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40291</b></p> <p>Based on interview and record review, the facility failed to ensure a resident's right to be free from abuse was not violated, when three residents (Residents #1, #2, and #3) were involved in two physical resident to resident altercations (Resident #1 and #2) and (Resident #1 and #3). Resident #1 was involved in a resident to resident altercations two days in a row and suffered a nose bleed as a result of Resident #3 hitting him/her in the nose. The sample was seven. The census was 139.</p> <p>The facility was notified of the past non-compliance on 12/20/24. Facility staff immediately intervened, notified administration, separated the residents, and provided assessment and services to the involved residents. The deficiency was corrected 12/14/24.</p> <p>Review of the facility's Abuse and Neglect Policy, revised 6/12/24, showed:</p> <p>-It is the policy of this facility to report all allegations of abuse to the Administrator of the facility immediately and to other appropriate agencies in accordance with current state and federal regulations within prescribed time frames;</p> <p>-Abuse is 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;</p> <p>-The facility will investigate all allegations and types of incidents;</p> <p>-The facility will take all necessary corrective actions depending on the results of the investigation;</p> <p>-Staff will identify residents with increased vulnerability for abuse or who have needs and behaviors that might lead to conflict. Through the care planning process, staff will identify any problems, goals, and approaches which would reduce chances of mistreatment for these residents;</p> <p>-Residents who allegedly mistreat another resident will be removed from contact with the resident during the investigation. The accused resident's condition shall be immediately be evaluated to determine the most suitable therapy, care approaches, and placement considering his or her safety, as well as the safety of other residents.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/15/24, showed:</p> <p>-Cognitively intact;</p> <p>-No behaviors exhibited;</p> <p>-Diagnoses included high blood pressure, diabetes, anxiety disorder, manic depression, and post-traumatic stress disorder (PTSD, a mental health condition that can develop after someone experiences or witnesses a traumatic event).</p> <p>Review of Resident #1's care plan, in use during the survey, showed:</p> <p>-Problem: On 12/13/24, the resident was involved in a resident-to-resident altercation with his/her peer, Resident #2. Root cause analysis showed that Resident #2 believed that Resident #1 called him/her a racial slur and hit him/her in the face. Resident #1 struck his/her peer back. Staff was present and able to separate residents. Resident #1 denied that he/she made a racial slur;</p> <p>-Goal: Resident #1 will have protective oversight through next review;</p> <p>-Interventions: Skin assessment completed, and no injury was noted. Neurological (Neuro) checks initiated and were within normal limits. Physician, guardian, and psychiatrist notified. Resident #1 was sent to the emergency room for a medical exam. Social Services Director (SSD) will meet with the resident to ensure there was no psychosocial impacts related to that event. He/She will continue to be encouraged to work with counseling and attend anger management classes as well as therapeutic groups. He/She will continue to meet with Interdisciplinary team (IDT) three times a week to review triggers and coping mechanisms.</p> <p>Review of Resident #1's progress notes, dated 12/13/24, showed:</p> <p>-At 3:47 P.M., Resident #1 said he/she was standing in the hall when Resident #2 walked up to him/her and said, Why you lie on me. Then Resident #1 proceeded to say he/she did not lie on Resident #2. Resident #1 said that Resident #2 buckled up and hit him/her, so they started fighting. Resident #2 hit Resident #1 on the right side of his/her face and also busted his/her nose. Both parties were sent out to two different local area hospitals. Both left by emergency medical services (EMS), two emergency medical technician (EMT)s via stretcher. The Director of Nursing (DON), guardian, and physician were notified. Resident #1 was to be placed on neuro checks for twenty-four hours;</p> <p>-At 10:58 P.M., Resident #1 returned from the hospital with no new orders. Resident #1 voiced no complaints of pain or discomfort at that time. No bruising noted at that time. The resident was calm and interacted with staff and other residents without difficulty.</p> <p>Review of Resident #2's quarterly MDS, dated [DATE], showed:</p> <p>-Cognitively intact;</p> <p>-Behaviors: Delusions marked;</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Diagnoses included: Epilepsy (seizure disorder), anxiety disorder, depression, manic depression, psychotic disorder and schizophrenia (a psychotic disorder or a group of disorders marked by severely impaired thinking, emotions, and behaviors).</p> <p>Review of Resident #2's care plan, in use during the survey, showed:</p> <p>-Problem: On 12/13/24, the resident was the aggressor in an altercation with his/her peer, Resident #1. Root cause analysis showed that Resident #2 believed that Resident #1 called him/her a racial slur. Resident #2 struck Resident #1 in the face and Resident #1 struck Resident #2 back. Staff were present and able to separate residents.</p> <p>-Goal: Resident #2 will have no aggressive behaviors through next review;</p> <p>Interventions: Skin assessment completed, and no injury was noted. Neuro checks initiated and were within normal limits. Physician, guardian, and psychiatrist notified. Resident #2 was sent to the emergency room for a psychiatric and medical exam. Resident #2's medications were under review by the psychiatrist and will continue to be monitored. SSD will meet with the resident to ensure there were no psychosocial impacts related to that event. He/She will continue to be encouraged to work with counseling and attend anger management classes as well as therapeutic groups. Upon arrival, the resident will be placed on one-on-one monitoring until deemed safe by administration.</p> <p>Review of Resident #2's progress notes showed:</p> <p>-12/13/24, at 3:36 P.M., Resident #2 stated Resident #1 called him/her a nigger. Resident #2 also stated he/she Don't go for that being called a nigger shit. Resident #2 walked up to Resident #1 and said he/she was Not on that racist stuff then proceeded to hit Resident #1 in the face. Both residents started punching each other. Both residents were sent out to different local area hospitals. Both residents left by EMS, two EMTs via stretcher. DON, guardian, and physician were notified;</p> <p>-12/14/24 at 7:09 A.M., The resident returned from the hospital to the facility via ambulance and two EMTs, after being evaluated at the local area hospital due to agitation and aggressive behaviors involving another resident. The resident was alert and oriented times three to four (person, place, time and situation). Resident had no indications of acute distress or discomfort and denied any pain or discomfort at the time of arrival. The orders were verified and approved by his/her physician. Neuro assessment performed with results consistent with the resident's baseline prior to leaving the facility. Resident displayed no signs of aggression, or inappropriate behavior. Will continue to monitor and provide protective oversight. No other concerns were present. Management, physicians, and guardian made aware of arrival and findings while hospitalized . Plan of care ongoing.</p> <p>Review of the facility's investigation dated 12/16/24, showed:</p> <p>-Code [NAME] (behavior emergency) called on 600 hall (on 12/13/24) at 3:00 P.M. Per witnesses, Resident #2 walked up to Resident #1 and struck him/her in the face, and Resident #1 struck Resident #2 back.</p> <p>-Certified Nurses Assistant (CNA) B was sitting on 600 hall when he/she heard Resident #2 loudly say something. CNA B looked up, and Resident #2 and Resident #1 were exchanging blows. CNA B got up to intervene. He/She was able to separate the residents.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-CNA C said he/she was walking towards the nurse's station and when he/she looked towards the 600 Hall, he/she saw Resident #2 punch Resident #1 in the face. The Code [NAME] was called. Resident #2 then walked away to the day room.</p> <p>-CNA A said Resident #1 walked down the hall and Resident #2 came out of his/her room and walked up to Resident #1. Resident #2 made the statement You on that racist shit then hit Resident #1 in the face, and the fight broke out.</p> <p>-Resident #2 told the DON that on Thursday evening, 12/12/24, Resident #2, Resident #1, and another resident were together. The other resident made a racist comment but apologized. Resident #1 was there and laughed at the joke but never apologized. Resident #2 never reported the incident to any staff. The other resident stated Thursday evening he was with Resident #1 and Resident #2 in his/her room. He/She admitted he/she did make a racist comment and apologized. Resident #1 did not say anything. Resident #1 denied making any racial comments to Resident #2. Resident #1 did admit to laughing when the other resident made the racial comment;</p> <p>-Conclusion/ outcome of the investigation: Allegation substantiated;</p> <p>-Care plan changes and interventions: Resident #1: Skin assessment completed, and no injury was noted. Neuro checks initiated and were within normal limits (WNL). Physician, guardian, and psychiatrist notified. Resident #2 was sent to the emergency room (ER) for a psychiatric and medical exam. Resident #2's medications were under review by the psychiatrist and will continue to be monitored. SSD will meet with Resident #2 to ensure there are no psychosocial impacts related to that event. He/She will continue to be encouraged to work with counseling and attend anger management classes as well as therapeutic groups. Upon arrival, he/she will be placed on one-on-one monitoring until deemed safe by administration. Resident #1: Skin assessment completed, and no injury was noted. Neuro checks initiated and WNL. Physician, guardian, and psychiatrist notified. Resident #1 was sent to the ER for a medical exam. SSD will meet with Resident #1 to ensure there were no psychosocial impacts related to that event. He/She will continue to be encouraged to work with counseling and attend anger management classes as well as therapeutic groups. He/She will continue to meet with IDT three times a week to review triggers and coping mechanisms.</p> <p>During an interview on 12/16/24 at 1:10 P.M., Resident #2 said he/she had been at the facility for over one year. He/She did hit another resident, Resident #1. He/She hit Resident #1 because he/she used a racial word and was laughing about it. It was in the hallway out there. Resident #2 was not aware if staff were around or not. Resident #1 used a racial slur one day and Resident #2 hit him/her the next day. Resident #2 thought about it all that day and night, and then the next day he/she hit Resident #1. Both of them were sent out. There were no bruises or marks. They moved Resident #1 off the hallway. Right now, he/she is on one-on-one monitoring due to this incident that happened the day before yesterday.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/16/24 at 3:28 P.M., Resident #1 said he/she and Resident #2 had a resident-to-resident altercation. The incident happened inside another resident's room. Resident #1 said Resident #2 thought he/she had said the N word. Resident #1 said he/she hadn't said the N word. This incident had taken place on one day, and Resident #2 hit him/her the next day. They were passing each other in the hallway. Resident #2 said What you say about racial comments? Resident #1 said he/she Didn't say no racial comments, Resident #1 laughed and then Resident #2 hit Resident #1. CNA A was in the area at the time of the incident. Resident #2 hit Resident #1 three times, then CNA A intervened and called a Code Green. Resident #2 kept trying to hit him/her. Resident #1 didn't remember if he/she hit Resident #2 back or not. A bunch of staff came in and took Resident #1 off the hall and sat him/her at the nurse's station and told him/her that he/she was going out. He/She went to the hospital and came back that night, and he/she went back into his/her same room on the 600 hall.</p> <p>During an interview on 12/16/24 at 1:17 P.M., CNA A said he/she been working at the facility since 2021 and was doing the one-on-one monitoring with Resident #2. This was not his/her first time working with Resident #2. Resident #2 has had issues of aggression in the past. CNA A was at work, working on the hall the day of the incident. CNA B was working on the hall also. The incident happened around 2:00 P.M., or 2:15 P.M., on 12/13/24. Resident #2 hears voices. He/She walked out of his/her room and Resident #1 was walking up the hallway. Resident #1 said Resident #2 walked up to him/her and asked him/her if he/she was Still on that racist shit. Resident #1 asked Resident #2 what was he/she was talking about. Resident #2 then just swung and hit Resident #1. Resident #2 was hearing voices at the time. He/She had already been showing signs of paranoia and aggressive behaviors. Prior to the incident, Resident #2 had been throwing stuff out of the room, slamming doors, and yelling and cussing. CNA A had tried to deescalate the situation. Usually, Resident #2 is very easy to redirect but that day he/she wasn't.</p> <p>During an interview on 12/16/24 at 2:10 P.M., CNA B said he/she was familiar with Resident #2 and Resident #1. The residents did have an incident this past Friday evening on 12/13/24. CNA B was on the 600 hall, there were about three staff total working on the hall at the time. CNA B heard Resident #2 yell out something. He/She yells stuff sometimes. The staff are used to it. CNA B looked up, and the residents were exchanging blows. CNA B did not know who started it or who threw the first lick. CNA B asked the other staff person to call a Code Green, and he/she walked towards the residents to break it up. CNA B was at the back of the hall, and the residents were at the front of the hall. CNA B was able to get them separated immediately, told Resident #2 to stop, and he/she stopped. The other staff person took Resident #2 outside. This was Resident #2's first fight that CNA B knew of. CNA B asked Resident #2 what happened, and he/she said the night before Resident #1 called him/her the N word. CNA B guessed Resident #2 had thought about it all day and night, and he/she decided to hit Resident #1 the next day on 12/13/24. The two residents had said nothing to each other the whole day. Resident #2 had been in his/her room most of the day. The incident happened on the evening shift. CNA B normally works days, but he/she had stayed over. By the time the Code [NAME] crew arrived, the altercation was broken up.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/19/24 at 12:25 P.M., CNA C said he/she was familiar with Resident #2 and Resident #1. CNA C wasn't assigned on the 600 hall at the time; he/she was at the nurse's station. He/She was coming out of the dining room when he/she happened to look to his/her left and saw Resident #2 and Resident #1. Resident #2 had his/her fists up and punched Resident #1 twice. By the time that happened, staff were calling a Code Green. CNA C called it as well. From what he/she saw, Resident #2 hit Resident #1 first. CNA C asked Resident #2 what happened, and he/she said Resident #1 called him the N word the day before. CNA B jumped in to break it up. CNA C didn't see any bruises on Resident #1, just redness to the face. Both residents were sent out. CNA C didn't know if any of the residents had issues in the past with other residents or not. Staff receive abuse and neglect trainings every couple of months, at meetings or on pay days. The last abuse and neglect training he/she attended was probably about a month ago.</p> <p>2. Review of Resident's #3's quarterly MDS, dated [DATE], showed:</p> <p>-Cognitively intact;</p> <p>-No behaviors;</p> <p>-Diagnoses included high blood pressure and schizophrenia.</p> <p>Review of Resident#3's care plan, in use during the survey, showed:</p> <p>-Problem: On 12/14/24, the resident was involved in an altercation with his/her peer, Resident #1. Root cause analysis showed that Resident #1 was sitting in the chair for staff and refused to move. Staff was working with Resident #1 when Resident #3 came up to him/her and attempted to remove Resident #1 from the chair, resulting in a physical altercation. Staff were present and worked to separate the residents;</p> <p>-Goal: Resident will have no physically aggressive behaviors through next review;</p> <p>-Interventions: Skin assessment completed, and no injury was noted. Neuro checks initiated and were within normal limits. Physician, guardian, and psychiatrist notified. Resident #3 was sent to the emergency room for a medical and psychiatric exam. SSD will meet with the resident to ensure there were no psychosocial impacts related to that event. He/She will continue to be encouraged to work with counseling and attend anger management classes as well as therapeutic groups. He/She will continue to meet with IDT weekly to review triggers and coping mechanisms. Residents will be trialed on separate halls. Resident #3 will be on one-on-one monitoring until deemed safe by administration.</p> <p>Review of Resident #3's progress notes, dated 12/14/24 showed:</p> <p>-At 4:16 P.M., a Code [NAME] was called to the 600 hall to de-escalate a verbal altercation between two residents, Resident #3 and Resident #1, involving Residents #1 sitting in a chair. During the immediate separation of the residents, Resident #3 swung over the top of the staff and hit Resident #1 in the nose;</p> <p>-At 10:59 P.M., Resident #3 returned to the facility from the hospital and was placed on one-on-one monitoring.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #1's care plan, in use during the survey, showed:</p> <p>-Problem: On 12/14/24, the resident was involved in a resident-to-resident altercation with his/her peer, Resident #3. Root cause analysis showed that Resident #1 was sitting in the chair for staff and refused to move. Staff were working with Resident #1 when Resident #3 came up to him/her and attempted to remove the chair from behind Resident #1, resulting in a physical altercation. Staff were present and worked to separate the residents;</p> <p>-Goal: Resident #1 will have protective oversight through next review;</p> <p>Interventions: Skin assessment completed, and Resident #1 had a bloody nose. Neuro checks initiated and were within normal limits. Physician, guardian, and psychiatrist notified. Resident #1 was sent to the emergency room for a medical exam. SSD will meet with the resident to ensure there was no psychosocial impacts related to that event. He/She will continue to be encouraged to work with counseling and attend anger management classes as well as therapeutic groups. He/She will continue to meet with the IDT three times a week to review triggers and coping mechanisms. Resident #1 will be trialed on a different unit. He was on one-on-one monitoring until deemed safe by administration.</p> <p>Review of the facility's investigation dated 12/16/24, showed:</p> <p>-Code [NAME] called to the 600 hall (on 12/14/24) to de-escalate a verbal altercation between Residents #1 and #3 involving sitting in a chair. During the immediate separation of the residents, Resident #3 swung over the top of the staff and hit Resident #1 in the nose. Hall Monitor (HM) D said Resident #1 was sitting in the chair by the door. Staff asked Resident #1 to get out of the chair, but he/she refused. It was smoke time, and the residents were getting upset because smoke time was taking longer due to Resident #1 refusing to get up. He/She was cursing back and forth with other residents because they were telling him/her to get up. Resident #3 was standing by the door and was mad because he/she was ready to smoke. Resident #3 told Resident #1 to get out of the chair, and he/she refused. Resident #3 went to physically get Resident #1 out of the chair. Resident #1 then swung on Resident #3 but did not make contact. Staff tried to diffuse the situation, but it happened so fast. Residents #1 and #3 started fighting. Resident #3 just started swinging. Resident #1's nose was bleeding.</p> <p>-CNA E said Resident #1 was sitting in the staff's seat and was asked to move. Resident #1 refused to move, and this was upsetting the residents because it was cutting into their smoke time. Resident #3 went to reach to get Resident #1 out of the chair. Resident #1 swung but missed. Resident #3 hit back and made Resident #1's nose bleed. Staff tried getting between then to break it up. Resident #3 was the only resident that was not redirectable;</p> <p>-Conclusion/Outcome of the investigation: Resident #1 said Resident #3 grabbed him/her by the shirt to get him/her up out of the chair. Staff had been asking Resident #1 to get out of the chair. Resident #1 got up out of the chair. He/She tried to gouge Resident #3's eyes but didn't. Resident #3 hit Resident #1 in the nose. Resident #3 said Resident #1 was sitting in the chair on 600. Staff were trying to get him/her out the chair. Resident #1 was holding up smoke break. Resident #3 grabbed Resident #1's arm to get him/her out of the chair. Resident #1 tried to eye gouge him/her but did not do it. Resident #3 was trying to walk away, but Resident #1 kept going at Resident #3, so Resident #3 hit him/her.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Allegations substantiated. Both patients were sent to the hospital and returned with no new orders. No injury to either party. Resident #1 was placed on neuro checks. Both parties were placed on one-on-one monitoring;</p> <p>-Care plan, changes and interventions: Resident #3's skin assessment completed and no injury was noted. Neuro checks initiated and were within normal limits. Physician, guardian, and psychiatrist notified. Resident #3 was sent to the ER for a medical and psychiatric exam. SSD will meet with Resident #3 to ensure there are no psychosocial impacts related to this event. He/She will continue to be encouraged to work with counseling and attend anger management classes as well as therapeutic groups. He/She will continue to meet with IDT weekly to review triggers and coping mechanisms. Residents will be trialed on separate halls. Resident #3 was placed on one-on-one monitoring until deemed safe by administration. Resident #1: Skin assessment completed and he/she was noted to have a bloody nose. Neuro checks initiated and within normal limits. Physician, guardian, and psychiatrist notified. Resident #1 was sent to the ER for a medical exam. SSD will meet with Resident #1 to ensure there were no psychosocial impacts related to this event. He/She will continue to be encouraged to work with counseling and attend anger management classes as well as therapeutic groups. He/She will continue to meet with IDT three times a week to review triggers and coping mechanisms. Resident #1 will be trialed on a different unit. Resident #1 will be placed on one-on-one monitoring until deemed safe by administration.</p> <p>During an interview on 12/16/24 at 1:06 P.M., Resident #3 said he/she did not want to talk about what happened on Saturday 12/14/24.</p> <p>During an interview on 12/16/24 at 3:28 P.M., Resident #1 said he/she did have an altercation with Resident #3. Resident #3 grabbed him/her out of the chair because staff told him/her to get up. Then he/she grabbed Resident #3 back and started punching him/her in the face. Staff were back there when it happened. Staff did intervene quickly and a Code [NAME] was called. The fight was broken up after the Code [NAME] crew arrived. Resident #1 said he/she was hit in the face and it still hurt under his/her right eye, but there was no other issues outside of a bloody nose. Both of the residents were sent to the hospital and came back a couple hours later.</p> <p>(continued on next page)</p>

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  12/20/2024
NAME OF PROVIDER OR SUPPLIER  Crestwood Health Care Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/16/24 at 3:00 P.M., HM D said he/she works the day shift and has worked at the facility for about three years. He/She worked on the 600 hall and was familiar with both residents. On the 600 hall, there are two chairs and a bedside table on the hallway, like where staff sit, so there would be someone at the top of the hallway, the bottom of the hallway and sometimes someone in the middle. Resident #1 was sitting at the top of the hallway in one of those seats. HM D's personal belongings were by Resident #1's foot, so he/she was asked if he/she could move to the next empty chair, which was in between the first and second chair. Resident #1 refused to move to that seat, and it was smoke time. Resident #1 wasn't listening, and he/she was moody. Resident #1 upset a few of the other residents on the hall, so they were trying to get him/her to get up. Resident #1 started cussing and fussing at the other residents. Staff directed everyone down the hall. Everyone listened and had gone down the hall, except Resident #3. They couldn't redirect him/her because Resident #3 said he/she was tired of this. Resident #3 walked as if he/she was going to walk around and down the hall, then he/she walked over to Resident #1 and said Come on, like he/she was going to help Resident #1 up. In the midst of that, Resident #1 swung on Resident #3 and once he/she swung on Resident #3, HM D and another staff person intervened. When Resident #1 swung on Resident #3, he/she didn't hit Resident #1 because they intervened and they called a Code Green. There were no punches ever thrown. Resident #1 was brought up to the front and Resident #3 was still on the hall. After the incident, Resident #3 was easy to redirect. Shortly after, the police and ambulance arrived. In the midst of the incident, Resident #1's nose did get busted. The minute the residents started fighting, staff instantly called Code [NAME] and intervened. Right now the residents are probably friends. He/She was sure one of them apologized to the other. They normally do. Both Residents were sent out. Neither resident had been aggressive in the past to HM D's knowledge. Staff receive in-services on abuse and neglect; the last one was done about two weeks ago.</p> <p>3. During an interview on 12/20/24 at 1:37 P.M., with the Administrator and the DON, the DON said regarding the first resident to resident altercation with Residents #1 and #2, Resident #2 was put on one-on-one monitoring upon his return to the facility from the hospital. With the second resident to resident incident with Residents #1 and #3, both residents were placed on one-on-one monitoring upon their return to the facility. In fact, they moved Resident #1 completely off the unit (600 hall) on Monday, 12/16/24, about 10:00 A.M., right after their morning meeting. Because Resident #1 was a high behavior resident and could trigger other residents with his/her behaviors, management thought why not see if Resident #1 could do better off the unit. It couldn't hurt. Resident #1 is currently doing great. He/she was already doing anger management counseling prior to both incidents. Resident #1 was also already on the IDT list. They just increased his/her visits. Resident #3 had no prior issue with Resident #1 and never had an incident with any other resident in the building. Resident #2 never had an issue with Resident #1. The last incident Resident #2 had with a resident was about nine months ago. They did the following interventions for all the residents involved: Placed them on one-on-one monitoring, sent to the hospital for evaluations, and the IDT got together as a team to see what was best for the residents.</p> <p>MO00246568</p> <p>MO00246611</p>		