

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 01/09/2025
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 - 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32847</p> <p>Based on observation, interview and record review, the facility failed to ensure one resident's right to be free from physical abuse was not violated when another resident hit the resident in the face, resulting in a black eye and the need for sutures (Residents #1 and #2). The census was 138. The sample was 20.</p> <p>The administrator was notified on 1/9/25, of the past non-compliance. The facility responded appropriately when the incident occurred. The residents were separated and were sent to the hospital for evaluation. Care was provided to injuries and the rooms were changed so the residents no longer resided on the same hall. Continued education on abuse and neglect provided to staff. The deficiency was corrected on 1/2/25.</p> <p>Review of the facility's Abuse and Neglect policy, revised 6/12/24, showed:</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>-Physical abuse: Purposefully beating, striking, wounding, or injuring any resident or any manner whatsoever mistreating or mistreating a resident in a brutal or inhumane manner.</p> <p>Review of the facility's Resident's Rights policy, revised 7/5/23, showed:</p> <p>-Purpose: To ensure that resident rights are protected;</p> <p>-Resident has a right to a dignified existence, self-determination, and communication with and access to persons and serves inside and outside the facility. Facility must protect and promote rights of each resident, including each of the following rights;</p> <p>-Freedom from abuse: Resident has the right to be free from verbal, sexual, mental, and physical abuse, corporal punishment and involuntary seclusion.</p> <p>Review of the facility's investigation report, dated 1/2/25, showed:</p> <p>-Date of incident 12/31/24;</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 - Actual harm</p> <p>Residents Affected - Few</p>	<p>-Persons involved: Resident #2 and Resident #1;</p> <p>-Date and time notified: 12/31/24 at 9:00 A.M.;</p> <p>-During a code green (code called when there is a resident exhibiting aggressive behaviors), Resident #1 was attempting to propel towards the incident the code green was called on despite being redirected and told to go to his/her room. A staff propelled the resident into Resident #2's room to remove him/her from harm's way. Moments later Resident #1 was wheeled out of the room backwards by a different staff and was noted with blood coming from above left eye. Resident #2 then came to the doorway yelling. He/She was aware there was a code being called but wanted Resident #1 out of his/her room. Licensed Practical Nurse (LPN) B said he/she was already on the hall dealing with another resident. He/She state while he/she was turning to walk down the hall, he/she saw Resident #1 in the doorway of Resident #2's room being cursed at loudly. When the resident was removed from the doorway, blood noticed coming from Resident #1's left eye.</p> <p>Review of Resident #2's medical record, showed:</p> <p>-A quarterly Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff) dated 10/11/24, showed the resident cognitively intact with no behaviors;</p> <p>-A progress note dated 12/31/24 at 11:37 A.M., multiple staff were on the hall dealing with an altercation when incident occurred. Resident noted standing in front of another resident using a very selective choice of words after punching him/her in his/her face. (Laceration noted to opposed residents left eye). Residents separated immediately. Resident stated he/she was kicked, which caused him/her to punch resident in the face. When assessed no injuries to aggressor noted. Stated he/she was not hit, but he/she knocked the shit out of him/her. 911 called. Two emergency medical services (EMS) staff and two police arrived and transported the resident to the hospital for evaluation.</p> <p>Review of Resident #2's medical record, showed:</p> <p>-A quarterly MDS, dated [DATE], showed severe cognitive impairment. No behaviors. Uses a wheelchair;</p> <p>-A progress note dated 12/31/24 at 12:07 P.M., staff present at the time of incident, dealing with an altercation when incident occurred. Resident noted in a peers doorway, with blood coming from his/her left eye and being cursed at by aggressor. Residents separated immediately. When asked what happen, resident stated he/she hit me. Laceration noted to left eye when assessed, 911 called by writer. Vitals obtained, within normal limits according to prior assessments before altercation occurred. Two EMS and police arrived for transport to the hospital;</p> <p>-A progress note dated 12/31/24 at 10:15 P.M., resident remains at hospital emergency room (ER) at this time awaiting ambulance for transport back to facility. Sutures placed at ER to be removed in 3 to 5 days. No other orders received during report from ER nurse;</p> <p>-A progress note on 1/1/25 at 8:17 A.M., resident returned to facility. Appears to be 4 to 5 sutures below the left eyebrow, orders to remove in 3-5 days. Resident moved to a different room for protective oversight. States he/she is in no pain.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Observation and interview on 1/9/25 at 7:49 A.M., showed Resident #2 sat in a wheelchair in his/her room. He/She said Resident #1 entered his/her room during a code green. He/She told Resident #1 to get out of his/her room and Resident #1 began to yell and then kicked him, so he/she punched him/her. He/She does realize what he/she did was wrong because not every resident in the facility is alert.</p> <p>Observation and interview on 1/9/25 at 7:55 A.M., showed Resident #1 lay in bed on his/her back. A dark bruise visible under the residents left eye. No sutures visible. He/She said he/she did not remember much but knows he/she got punched in the eye. He/She does not remember who did it or why. It does not hurt anymore.</p> <p>During an interview on 1/9/25 at 8:52 A.M., with the Director of Nursing (DON) and Assistant Director of Nursing (ADON), the ADON said she did complete the investigation into the incident between Resident #1 and Resident #2, but she was not witness to the incident. There were no staff present at the time. It was not found out until the resident was found to have an injury and staff began to ask questions, that there was an altercation. The DON said the investigation depended on what the residents involved had to say about the incident. The resident did get sutures, but they had already been removed. He/She only need two or three of them for a few days.</p> <p>During an interview on 1/9/25 at 12:10 P.M., the Administrator said residents have the right to be free from abuse, to include abuse from other residents. At the time the altercation took place, there was another altercation occurring on the hall. Resident #1 kept propelling towards the other altercation and was at risk, so a split decision was made to place him/her in a different resident's room. His/Her room was on the other side of the hall, and it was not possible to get the resident to his/her room without getting in the middle of the other altercation. Staff did what they felt was best at the time.</p> <p>MO00247310 and MO00247336</p>