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Form Approved OMB
No. 0938-0391

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 03/25/2025

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** 12724 Based on observation, interview and record review, the facility failed to ensure one resident's (Resident #2's) right to be free from physical abuse was not violated when Resident #1 hit Resident #2 in the head and face with a dismantled towel rack, which caused bruises to Resident #2. The facility also failed to ensure two other residents' rights to be free from abuse were not violated when the residents got into a fight (Resident #3 and #4) and Resident #4 sustained a swollen eye. The sample was eight. The census was 140. The Administrator was notified on 3/25/25, of the past non-compliance. The facility responded appropriately when the incident occurred. The residents were separated and received medical assessment and attention. Resident rooms were changed so Resident #1 no longer resides on the same hall as Resident #2, and Resident #3 no longer resides on the same hall as Resident #4. Counseling services were arranged for Residents #1 and #3. Continued education on behavior de-escalation techniques was provided to staff. The deficiency was corrected on 3/22/25. Review of the facility's Abuse and Neglect policy, revised 6/12/24, showed: -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; -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. 1. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/6/25, showed the following: -Cognitively intact; -Physical behaviors directed at others, occurred one to three days during the last seven days; -Verbal behaviors directed at others, occurred one to three days during the last seven days; -Other behaviors not directed at others, occurred one to three days during the last seven days; (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	-Diagnoses included: Anxiety and schizophrenia (serious mental illness that affects how a person thinks, feels, and behaves.) Review of Resident #1's care plan, in use during the abbreviated survey showed: -Problem: The resident has a history of being triggered by sounds. Interventions: Relaxation techniques (deep breathing, meditation, progressive muscle relaxation and guided imagery); -Problem: Resident has a history of behavioral challenges that require protective oversight in a secure setting. Interventions: Implement plans to change behavior, one on one interventions as needed, pharmaceutical interventions as needed; -Problem: The resident has a mood problem related to anxiety and schizoaffective disorder (mental health condition that includes features of both schizophrenia and a mood disorder.) Takes anticonvulsant medications that help stabilize his/her mood. Interventions: Administer medications as ordered, monitor/document side effects and effectiveness; behavioral health consults as needed; monitor/document/report any risk for harm to self; monitor/record/report to physician acute episode feelings or sadness. Review of Resident #1's progress notes showed: -On 3/13/25 at 6:33 P.M., resident was involved in an altercation with another resident on the secured unit. Director of Nursing (DON), physician and guardian notified of the incident; -On 3/13/25 at 8:10 P.M., new skin issue. Location: Posterior neck. Laterally/orientation: Middle. Issue type: Abrasion. Wound acquired in-house. Wound is new. Review of Resident #2's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Physical behaviors directed at others, occurred one to three days during the last seven days; -Verbal behaviors directed at others, occurred daily; -Other behaviors not directed at others, occurred daily; -Diagnoses included: Anxiety, bipolar disorder (mood disorder that can cause intense mood swings) and post-traumatic stress disorder (PTSD, mental health condition caused by a stressful or terrifying event.) Review of Resident #2's care plan, in use during the abbreviated survey showed: -Problem: Resident has potential to be verbally/physically aggressive related to a history of such and diagnoses of bipolar disorder, mood disorder and PTSD. -Interventions: (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Administer medications as ordered. Monitor/document side effects and effectiveness; -Analyze times of day, places and circumstances, triggers and what de-escalates behavior and document; -Assess and anticipate resident needs, food, thirst, toileting needs, comfort level, body positioning, pain, etc; -Communication: Provide physical and verbal cues to alleviate anxiety, give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behaviors, encourage seeking out a staff member when agitated; -Give the resident as many choices as possible about care and activities; -Monitor/document/report any signs/symptoms of resident posing a danger to self and others; -4/3/24, resident was set-up with counseling services; -When resident becomes agitated: Intervene before agitation escalates, guide away from source of distress, engage calmly in conversation. If response is aggressive, walk away calmly and approach later. Review of Resident #2's progress notes showed: -On 3/13/25 at 6:26 P.M., resident involved in an altercation with another resident. Physician, guardian and DON notified of incident. Neuro (neurological) checks initiated. STAT (immediate) x-ray of face/skull ordered and called into x-ray company; -On 3/13/25 at 8:47 P.M., hematomas (localized collection of blood outside the blood vessels) noted to left forehead, top of head and back of head. Review of Resident #2's x-ray report, dated 3/14/25 at 9:11 A.M., showed no acute skull abnormality observed. Review of the Administration/Registered Nurse (RN) Investigation, dated 3/14/25, showed the following: -Date of incident: 3/13/25; -Type of incident: Physical aggression involving head; -Investigative Narrative Note: Per Resident #1's statement, they were waiting to smoke at the back of the hall. Resident #1 saw Resident #2 looking at money on the table and told Resident #2 not to touch the money. Resident #2 said I don't have to listen to you. Resident #1 told Resident #2 to stop staring at him/her. Resident #1 said Resident #2 then charged at him/her and grabbed his/her wrist. Resident #1 then grabbed a pipe he/she had stashed a few days ago and started hitting Resident #2 in the head and face with the pipe. Resident #2 grabbed Resident #1's groin and pinched, squeezed and scratched the back of his/her neck. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Per Resident #2's statement, he/she was on the hall playing with another peer when Resident #1 told him/her to stop messing with the peer and to stop looking at him/her (Resident #1). Resident #1 grabbed a pole, and Resident #2 tried to protect him/herself by grabbing Resident #1's wrists. Resident #1 hit Resident #2 several times before staff were able to break it up. -Conclusion: Allegations are substantiated. Both parties were separated. Resident #1 was immediately removed from the hall and placed on one-on-one. Resident #2 was placed on neuro checks. Skin assessments completed on both residents. STAT x-ray completed for Resident #2. Social services to meet with both parties. -Care plan changes and interventions: Resident #1 will meet with interdisciplinary team to discuss and identify coping skills. Resident #1 will attend anger management group in addition to continuation of one-on-one counseling. Psychiatrist to evaluate medication. Resident #1 to meet with social worker to discuss any psychosocial effects that may have occurred from event. Towel bars were removed from Resident #1's room. Social services to meet with Resident #2 to ensure there are no psychosocial impacts related to this event. Psychiatrist to review medication. Neuro checks initiated and within normal limits (WNL). Skull x-ray ordered. -Criteria for self-reporting: -Was this a result of abuse?: Yes; -Was there a physical altercation?: Yes; -Was the altercation preventable?: Yes. During an interview on 3/24/25 at 3:15 P.M., Maintenance Associate A said he/she also works as a hall monitor at times. The incident with Resident #1 and #2 occurred around smoke time, and staff called a Code [NAME] (behavior emergency). Staff responded. Resident #1 was hitting Resident #2 with a towel rack. Resident #1 doesn't normally bother people unless he/she is provoked. Resident #2 can be a bully, and the other residents get tired of it. During an interview on 3/24/25 at 3:25 P.M., Hall Monitor (HM) B was at the top of the hall and another staff member was passing medications at the bottom of the hall. The incident between Resident #1 and #2 occurred in the evening at the bottom of the hall. HM B was not aware of anything going on earlier in the day between the two residents and had not received anything in report from the previous shift about the two residents. Resident #1 hit Resident #2 with a towel rack. HM B has no idea how Resident #1 got a dismantled towel rack. That was unexpected. Staff called a Code [NAME] and other staff responded. They separated the residents. HM B has worked at the facility for a couple of months and has never seen Resident #1 being physically aggressive before. HM B has never seen Resident #1 and #2 fight before. Resident #2 can be spoiled and get his/her way. Observation on 3/24/25 at 10:45 A.M. and at 2:00 P.M., showed Resident #1 resting in bed with a staff member in the room. Observation and interview on 3/25/25 at 10:45 A.M., showed Resident #2 resting in his/her bed on a different hall with no visible injuries observed. The resident said he/she had been getting along with everyone fine since he/she moved to his/her new room and hall. (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 3/14/25 at 12:27 PM., the Administrator said she thought Resident #1 was hearing voices on 3/13/25. Resident #2 did nothing to Resident #1. They were waiting for smoke time. Resident #1 saw Resident #2 looking at money on the table and told him/her not to touch it. Resident #2 said he/she didn't have to listen to Resident #1. Resident #1 told Resident #2 to stop staring at him/her. Resident #1 then hit Resident #2 with a towel bar. They did a STAT x-ray of face and skull on Resident #2, which was negative. Resident #2's nose was bleeding, and he/she sustained hematomas to the left forehead, top and back of the head. Resident #1 was placed on one-on-ones for 72 hours and will be seen by psychiatric services for a medication adjustment. During interviews on 3/24/25 at 12:50 P.M. and on 3/25/25 at 12:15 P.M., the DON said maintenance staff removed the other towel rack from Resident #1's room the night of the incident. The DON has no idea when/how Resident #1 dismantled the towel rack. The neck abrasion noted in Resident #1's progress notes was likely due to the altercation because it wasn't noted in the pervious week's skin assessment. Resident #1 is normally very quiet but occasionally just snaps. One of their new interventions for Resident #1 is counseling services. 2. Review of Resident #3's annual MDS, dated [DATE], showed the following: -Mild cognitive impairment; -Delusions; -No behaviors; -Diagnoses included: Anxiety, depression, psychotic disorder and schizophrenia. Review of Resident #3's care plan, in use during the abbreviated survey, showed: -Problem: Resident has the potential to be verbally/physically/sexually abusive; -Interventions: -Administer medications as ordered. Monitor/document side effects and effectiveness; -Assess and address for contributing sensory deficits; -Analyze times of day, places and circumstances, triggers and what de-escalates behavior and document; -Assess and anticipate resident needs, food, thirst, toileting needs, comfort level, body positioning, pain, etc; -Communication: Provide physical and verbal cues to alleviate anxiety, give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behaviors, encourage seeking out a staff member when agitated; -4/11/24, resident will meet weekly with interdisciplinary team to speak about frustrations and coping mechanisms. He will be referred to internal counseling services; (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Give the resident as many choices as possible about care and activities; -Monitor/document/report any signs/symptoms of resident posing a danger to self and others; -When resident becomes agitated/aggressive, resident states he can at times calm down by laying in his room with the lights out or watching TV alone in his/her room; -When resident becomes agitated: Intervene before agitation escalates, guide away from source of distress, engage calmly in conversation. If response is aggressive, walk away calmly and approach later. Review of Resident #3's progress notes showed on 3/22/25 at 9:22 A.M., Resident #3 and a peer were embraced in a bear hug after a Code [NAME] was called. Both residents were immediately separated. Peer taken off hall immediately and assessment started. No visible injuries noted to Resident #3. Resident #3 said he/she was tired of his/her peer talking crap to everybody. Residents immediately separated and placed on one-on-one. Skin assessments completed. All parties notified of occurrence. Review of Resident #4's quarterly MDS, dated [DATE], showed the following: -Cognitively intact; -No behaviors; -Diagnoses included: Psychotic disorder and schizophrenia. Review of Resident #4's care plan, in use during the abbreviated survey, showed: -Problem: Resident has potential to be verbally/physically aggressive resulting in Code Green; -Interventions: -Administer medications as ordered. Monitor/document side effects and effectiveness; -Assess and anticipate resident needs, food, thirst, toileting needs, comfort level, body positioning, pain, etc; -Communication: Provide physical and verbal cues to alleviate anxiety, give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behaviors, encourage seeking out a staff member when agitated; -Monitor/document/report any signs/symptoms of resident posing a danger to self and others; -Resident has agreed to attend anger management classes. Resident will often leave classes early and needs encouragement to participate; -Psychiatric/psychogeriatric consults as indicated; (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident gets increasingly agitated and aggressive when placed on one-on-ones. He does better speaking with male staff separately when possible; -Social worker will petition the court for guardianship; -When resident gets upset, remove resident from the situation immediately. Monitor resident visually and let him/her walk away and cool down; -When resident becomes agitated: Intervene before agitation escalates, guide away from source of distress, engage calmly in conversation. If response is aggressive, walk away calmly and approach later. Review of Resident #4's progress notes showed the following: -On 3/22/25 at 9:19 A.M., resident was struck in the right eye by another resident. Both residents immediately separated and assessed. Resident #4 was taken off the hall and transferred to another room (on another hall). Resident refused to cooperate with vital signs and neuro checks and said Ya'all act like you have never seen a fight. I ain't talking about nothing. Resident refused to answer questions. Skin assessments completed and resident verbally denied pain. All parties notified. Resident refused vital signs. -On 3/22/25 at 3:21 P.M., resident remains on incident follow up for resident to resident without any further incidents this shift. Resident's right eye remains swollen. Tried to give resident ice pack, but he/she refused. Remains on neuro checks which were WNL. Review of the Administration/RN Investigation, dated 3/24/25, showed the following: -Date of incident: 3/22/25; -Type of incident: Physical aggression involving head; -Investigative Narrative Note: On 3/22/25 at 8:25 A.M., a Code [NAME] was called on the secured unit. Resident #3 had hit Resident #4 in the eye. Resident #4 bear hugged Resident #3. The Housekeeping Supervisor (HS) said Resident #3 walked past Resident #4 and called him/her out. The HS told staff to take Resident #4 off the hall and asked the certified medication technician (CMT) to come down the hall to give Resident #3 his/her medications so Resident #3 would not have to walk by Resident #4. Resident #4 yelled, I need my fucking meds. Resident #4 walked into his/her room and then came back out, walked up to Resident #4 and said What you want to do. Then Resident #3 hit Resident #4 in the face. The residents were separated. RN C said he/she was on the hall and heard the Code [NAME] called. Resident #3 and #4 were in a bear hug and immediately separated. (continued on next page)

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F 0600

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

CMT D said after announcing medication time, Resident #3 walked up the hall. Resident #4 was standing behind CMT D, talking to him/herself. As soon as Resident #3 started walking toward the medication cart, Resident #4 started cussing and calling Resident #4 names. Resident #3 started acting aggressively, and the HS and CMT got between the two residents. Prior to the incident, CMT D took Resident #3 off the hall and got him/her some coffee. When they returned to the hall, Resident #4 was talking, and CMT D told him/her to stop. CMT D was preparing Resident #3's medications when he/she heard a loud noise. CMT D looked up and saw the residents bear hugging. Staff called a Code [NAME] and separated the residents.

HM E said Resident #4 was cursing at Resident #3, and Resident #3 went back to his/her room.

-Conclusion/Outcome of Investigation: Resident #3 came back out to take his/her medications, but staff told him/her to go back in his/her room because Resident #4 was still fussing towards Resident #3. Resident #3 started to come back out of his/her room, and Resident #4 was leaning against the wall. Resident #3 hit Resident #4, and they started fighting. Staff called a Code [NAME] and broke up the residents. Resident #4 was removed off the hall. Resident #3 was placed on one-on-one, and Resident #4 was placed on neuro checks. Resident #4 had some swelling to the right eyelid.

Resident #4 said he/she did not know what happened. Resident #4 said Resident #3 just stole on me. Resident #3 hit me on the right side of my eye and then grabbed me. I did not get a chance to hit him/her back.

Resident #3 said he/she was sick of hearing Resident #4's mouth. Resident #4 was singing all morning, waking everyone up. While in line, Resident #4 was talking shit and nit picking. So I hit him/her. Allegations are substantiated.

-Care plan changes and interventions: Resident #3: Residents were immediately separated. Psychiatrist to evaluate medications. Resident was placed on one-on-one. Resident was enrolled in one-on-one counseling. Resident will meet with interdisciplinary to discuss triggers and coping mechanisms.

Resident #4: Resident was moved to another hall. Labs were ordered. Resident will attend coping skills group. Resident to meet with social services to discuss any psychosocial effects from the incident.

-Criteria for self-reporting:

-Was this a result of abuse?: Yes;

-Was there a physical altercation?: Yes;

-Was the altercation preventable?: No.

During an interview on 3/24/25 at 2:45 P.M., CMT D said on the day of the incident, Resident #4 had been cussing at Resident #3, so CMT D took Resident #3 off the hall to get a cup of coffee. When they came back, Resident #3 was standing by the cart waiting for his/her medications. CMT D heard a thump. It all happened fast. Staff called a Code [NAME] and separated the residents. Resident #3 is usually calm as long as he has his/her coffee and his/her chew. Resident #3 doesn't like to see female staff disrespected.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/24/25 at 2:50 P.M., HM E said Resident #4 can get in a mood and cuss people out. HM E was at the top of the hall, saw the residents in a tussle and staff called a Code Green. During an interview on 3/24/25 at 3:00 P.M., the HS said on the day of the incident, Resident #3 had been off the hall and came back on the unit. Resident #3 went to his/her room, and then came back out and said he/she wanted his/her fucking meds. The HS wanted to keep Resident #3 and #4 separated but within 45 seconds of Resident #3 returning to his/her room, the incident happened. The HS called a Code [NAME] and tried to get in between the residents. Even though there were several staff on the hall at the time of the incident, they were all female and that makes it difficult when the residents are bigger than the staff. During an interview on 3/25/25 at 11:21 A.M., RN C said he/she was at the top of the hall doing Accu checks (blood glucose checks) when he/she saw the residents bear hugging. Staff immediately called a Code [NAME] and separated the residents. Resident #3 had no injuries. Resident #4 had a swollen right eye. Resident #3 said he/she was tired of Resident #4 talking. Resident #4 didn't want to talk about it. It has been a while since Resident #3's last physical altercation. Sometimes Resident #3 thinks people are talking about him/her when they are not. Observation and interview on 3/24/25 at 10:45 A.M., showed Resident #3 in his/her room with a staff member. The resident said he/she was on one-on-one monitoring for something that was no big deal. The resident had no visible injuries observed. When the resident got up to walk to another room, the staff member followed him/her. Observation and interview on 3/24/25 at 10:20 A.M., showed Resident #4 in his/her room on a different hall. The resident's right eyelid was swollen and the inside of the eye was pink. The resident said the eye did not hurt. Resident #4 said he/she and another resident got into a fight over something that happened way back from the neighborhood. They are from the same streets and the same neighborhood. Resident #4 had not had previous problems with Resident #3 while in the facility. Resident #4 knew he/she should have kept his/her mouth closed. Staff tried to put ice on the eye, but Resident #4 told them it didn't matter. Staff broke up the fight and have been checking on him/her. During an interview on 3/22/25 at 10:50 AM, the Administrator said at the time of the incident, both residents lived on the secured hall, and the incident occurred around 8:36 AM on 3/22/25. Resident #3 said Resident #4 was talking stuff; Resident #3 was tired of it and hit Resident #4. Resident #3 had just come back onto the unit with a cup of coffee and Resident #4, who was standing by the CMT waiting for his/her medications, wanted some of his/her coffee. Resident #3 said no, and went to his/her room, but then came back out of his/her room and went back down the hall and hit Resident #4. Staff did intervene and Resident #4 now lives on a different hall. Both residents said they were not hurt and had no pain, but Resident #4 had a slightly swollen right eye, but refused vital signs. They will be giving their coping skills group (run by facility Activities) and will be looking into one-on-one counseling for Resident #3. During an interview on 3/25/25 at 12:15 P.M., the DON said Resident #3 tends to cycle, and she thinks he/she is heading into the next cycle of behaviors. Resident #3 had a recent medication change. The resident has been quiet since the 3/22/25 incident. MO00251035 (continued on next page)

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