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	09/22/2025

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. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident's right to be free from abuse was not violated, when two residents (Residents #1 and #2) were involved in a resident-to-resident altercation. Resident #1 suffered a bloody lip as a result of Resident #2 hitting him/her in the mouth. The sample was 12. The census was 137.The Administrator was notified on 9/23/25 at 4:55 P.M., of the past non-compliance, which occurred on 9/16/25. The facility provided 1:1 for the residents and updated their care plans. The deficiency was corrected on 9/16/25. Review of the facility's Abuse and Neglect Policy, revised 6/12/24, showed:-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;-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;-The facility will investigate all allegations and types of incidents;-The facility will take all necessary corrective actions depending on the results of the investigation;-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;-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. Review of Resident #1's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/29/25, showed:-Cognitively intact;-No behaviors exhibited;-Diagnoses included high blood pressure, chronic obstruction pulmonary disease (COPD, lung disease) and schizophrenia (a psychotic disorder or a group of disorders marked by severely impaired thinking, emotions, and behaviors). Review of Resident #1's care plan, in use during the survey, showed:-Problem: On 9/16/25, the resident was hit by peer (Resident #2) for wearing pink and possibly being gay;-Goal: Resident #1 will be free from alterations through next review;-Interventions: Social Services (SS) to meet with the resident regarding any ill effects of yesterday events. Neuro checks and 72-hour monitoring; Review of Resident #1's progress notes, dated 9/16/25 at 6:49 P.M., showed the resident was outside during smoke break when another resident walked up to him/her and punched him/her in the face. The resident was already on a 1:1 for behaviors so his/her 1:1 was able to separate the resident but not before Resident #2 was able to hit Resident #1 in his/her face. The resident was noted to be bleeding from his/her mouth and he/she also noted to have an abrasion to his/her right elbow. The resident denied pain or discomfort. The area to elbow was cleansed and a dressing was applied. Vitals- Temperature (T) 98.3, Pulse (P) 78, Respirations (R) 18, Blood Pressure (BP)132/86, O2 98%. The resident was alert and answered questions appropriately. A call was placed to resident's family member and guardian to notify of altercation. The Physician and Director of Nursing (DON) were notified. Review of Resident #2's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Behaviors: Delusions;-Diagnoses included epilepsy (seizure disorder), anxiety disorder, depression, psychotic disorder, COPD and schizophrenia. Review of Resident #2's care plan, in use during the survey, showed:-Problem: On 9/16/25, the resident hit peer (Resident #1) due to him/her wearing pink and thinking he/she was gay;-Goal: Resident #2 will be free of physical altercations through next review;-Interventions: 1 on 1 until deemed safe. Psych was to review medications. Educated the resident that it was ok for anyone to wear pink and that they do not hit peers if they are gay. Review of Resident #2's progress notes, dated 9/16/25 at 6:50 P.M., showed staff went to Licensed Practical Nurse (LPN) C and reported that the resident stepped outside during smoke time and hit his/her peer, Resident #1 in the face. The resident stated Resident #1 was gay, and that he/she wore pink shirts, so Resident #2 hit him/her. The resident was assessed, and no injuries were noted. The resident denied complaints of pain or discomfort. Vitals: (T) 97.9, (P) 92, (R) 18, B/P-146/94, O2-97%. Call placed to the Physician, DON, and the resident's guardian. Review of the facility's investigation, dated 9/16/25, showed:-Certified Nurse's Aide (CNA) B reported to the DON that Resident #1 stepped outside to smoke and Resident #2 walked right up to Resident #1 and hit him/her in his/face. When the DON had gone to the hall, the residents had already been separated, and Resident #1 was standing at the nurses' station. Resident #2 was placed on one to one;-CNA A stated that he/she was