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	11/18/2025

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 - Immediate jeopardy to resident health or safety Residents Affected - Some	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

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(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 - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide on-going monitoring and close supervision of Resident #11, who had a history of being non-compliant with facility rules and policies by obtaining unauthorized and/or illegal drugs for both his/her own use as well as distribution to other residents. On [DATE], cardiopulmonary resuscitation (CPR, an emergency procedure used during cardiac or respiratory arrest that involves chest compressions, often combined with artificial ventilation, to preserve brain function and maintain circulation until spontaneous breathing and heartbeat can be restored) was initiated on Resident #11, Resident #1, and Resident #2 after an overdose. All three residents were sent to the hospital, and all three had drug screens that were positive for unauthorized and/or illegal substances. Review of the facility investigation/conclusion statement dated [DATE], showed the facility determined Resident #11 brought the unauthorized and/or illegal drugs into the facility and distributed them to Resident #1 and Resident #2. Resident #11 was readmitted to the facility on [DATE] and placed on one-on-one monitoring until [DATE]. On [DATE], Resident #11 exhibited behaviors that included being slow to respond and inappropriate laughter. Facility staff neglected to place Resident #11 on one-on-one monitoring and to obtain a drug screen at that time, not following facility policy. On [DATE], Resident #1, Resident #2, and Resident #3 were sent to the hospital, and all three residents' hospital drug screens were positive for unauthorized and/or illegal substances. The facility reviewed video footage from [DATE], which showed, Resident #1, Resident #2, and Resident #3 gave Resident #11 money that day and approximately one hour later, Resident #3 went into cardiac arrest (a life-threatening condition when the heart stops beating). CPR was initiated, and the resident was sent to the hospital where he/she was revived, but diagnosed with anoxic encephalopathy (a brain injury that occurs when the brain is completely deprived of oxygen, often due to events like cardiac arrest) and admitted to the hospital Hospice unit on [DATE]. Resident #1 and Resident #2 also exhibited symptoms of overdose that day and were sent to the hospital. All three residents' drug screens were positive for unauthorized and/or illegal substances. Resident #1 and Resident #2 said they had purchased the drugs from Resident #11 on [DATE]. In addition, Resident #29 tested positive for cocaine on [DATE] and said he/she had purchased it from Resident #11. Thirty-four residents were sampled, and problems were identified with five. (Residents #11, #3, #1, #2, and #29). The census was 133. The Administrator was notified on [DATE] at 11:39 A.M., of the Immediate Jeopardy (IJ) Past Non-Compliance which occurred on [DATE]. On [DATE], the Administrator became aware of the problem, and the facility began inservicing all staff on the Abuse and Neglect policy and procedure and Possession and Use of Illegal Drugs, Marijuana and Alcohol and Drug Screen and Searches policy. The IJ was corrected on [DATE]. Review of the facility Abuse and Neglect policy dated [DATE] and revised on [DATE], showed:-Purpose: It is the policy of this facility to report all allegations of abuse/neglect/exploitation or mistreatment, including injuries of unknown sources and misappropriation of resident property are reported immediately to the Administrator of the facility and to other appropriate agencies in accordance with current state and federal regulations within prescribed time frames;I. Neglect: Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress;Policy:-Guidelines: The Facility will develop and operationalize policies and procedures for screening and training employees, protection of residents and for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, and misappropriation of property. The purpose is to assure that the facility is doing all that is within its control to prevent occurrences;-Identification: The facility will identify events, occurrences, patterns and trends that may constitute mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property as defined above;-Alleged violation: A situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigated and, if verified, could be noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property;-Investigation: The facility will investigate all allegations and types of incidents as listed above in accordance to facility procedure for reporting/response as described below;-Protection: The facility will protect residents from harm during an investigation;-Reporting/Response: The facility will take all necessary corrective actions depending on the results of the investigation. The facility will analyze the occurrences to

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 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 staff notified one resident's physician regarding the resident's low blood pressure. In addition, the resident had two antihypertensive medications ordered, and one of those two medications was administered while the resident was hypotensive (blood pressure below 90/60) (Resident #7). The sample was 33. The census was 133.Review of the facility Notification Of Changes Policy, dated [DATE], showed:-Purpose: The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician, and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification;-Policy: The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification;-Circumstances Requiring Notification:2. Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status. This may include: Life threatening conditions, or clinical complications. Review of Resident #7's quarterly Minimum Data Set (MDS) a federally mandated assessment instrument completed by facility staff dated [DATE], showed:-Makes Self Understood: Understood;-Ability To understand Others: Understands;-Moderately impaired cognition;-Diagnoses of high blood pressure, Alzheimer's Disease, and schizophrenia (a psychotic disorder characterized by emotional responsiveness and disintegration of thought process). Review of the resident's care plan, located in the electronic medical record (EMR), showed:-[DATE], Problem: Hypertension (high blood pressure). Goal: Blood pressure will be within normal limits. Interventions: Evaluate blood pressure. Atenolol (medication/antihypertensive used to treat high blood pressure). Lorsartan potassium (medication/antihypertensive);-[DATE], Problem: Hypertension related to lifestyle choices, smoking. Goal: Will remain free of complications related to hypertension. Interventions: Give hypertensive medications as ordered. Monitor for side effect such as orthostatic hypotension and increased heart rate and effectiveness. Monitor/document/report PRN (as necessary) any signs/symptoms: Headache, visual problems, confusion, disorientation, lethargy, nausea and vomiting, irritability, seizure activity, difficulty breathing;-Alteration in neurological status related to disease process Alzheimer's disease. Goal: Will be able to communicate needs daily through the review date. Interventions: Cueing, reorientation as needed. Give medications as ordered, monitor/document side effects and effectiveness;-Coronary artery disease (the reduction of blood flow to the heart due to build-up of plaque in the arteries) related to atrial fibrillation (irregular heartbeat/rate). Goal: Will be free from signs/symptoms of complications of cardiac problems. Interventions: Educate the resident/family/caregivers about factors which might precipitate irregular heart rate. Give all cardiac medications as ordered by the physician. Monitor and document side effects. Report adverse reactions to physician PRN. Review of the resident's physician's order sheet, located in the EMR, showed: -Lorsartan potassium 50 milligrams (mg) one tablet by mouth once daily for hypertension;-Atenolol 50 mg one tablet every 12 hours for hypertension;-Full code (in the event the heart stops working or have no pulse, staff will start cardio pulmonary resuscitation (an emergency procedure used during cardiac or respiratory arrest that involves chest compressions, often combined with artificial ventilation, to preserve brain function and maintain circulation until spontaneous breathing and heartbeat can be restored).Review of the resident's medication administration record dated [DATE] through [DATE], and located in the EMR, showed:-[DATE]: MP 7a (morning pass, liberalized), lorsartan potassium 50 mg. The Certified Medication Technician (CMT) initialed the medication had been administered;-[DATE]: 9:00 A.M., atenolol 50 mg, the CMT documented a blood pressure (BP) of 78/67 (normal BP is 120 (systolic)/80 (diastolic)) and entered a 5/hold/see progress notes.Review of the resident's weights/vitals tab, located in the EMR, showed the CMT documented: [DATE] at 10:56 A.M., BP 78/67.Review of the resident's progress notes, located in the EMR, showed:-No documentation regarding the resident's BP of 78/67;-[DATE] at 3:49 P.M. and documented by Registered Nurse (RN) F: 11:00 A.M., resident observed lying in bed talking to this writer and treatment nurse while taking medication and supplement. Resident verbally denied pain when asked. 11:48 A.M., code blue (a medical emergency), coffee ground emesis (vomit that resemble coffee grounds due to the presence of old, coagulated blood, indicating bleeding in the upper gastrointestinal tract that requires immediate medical attention). No pulse, no respiration, CPR initiated, 911 called. 12:24 P.M., resident pronounced dead.During an interview on [DATE] at 6:58 A.M., Licensed Practical Nurse (LPN) R said if a resident had a BP of 78/67, he/she would hold any BP