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	05/01/2026

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to protect resident funds from misappropriation by not implementing a check and balance system. During cash disbursements, the facility allowed cash and receipt books to be issued to staff for distribution without reconciliation of funds and receipts upon return. This deficient practice enabled the business manager to alter receipts and remove funds from the cash box without detection, resulting in the potential for and actual misappropriation of resident money for 33 residents (#6, #8, #11, #14, #17, #27, #35, #38, #41, #42, #47, #52, #54, #56, #60, #64, #78, #79, #86, #93, #96, #100, #112, #114, #120, #127, #129, #132, #136, #140, #150 and #151) of the 101 resident's facility managed funds. The sample size was 32. The census was 141.Review of the facility's General Information Regarding Responsibilities of Holding Resident Funds policy, dated 3/1/17, showed:--The facility shall keep an accurate and maintained accounting system for the residents that choose to have their personal funds managed. These funds shall be safeguarded by the facility, using complete and separate accounting principles, which precludes any commingling of resident funds with facility funds;--Personal funds of the resident shall be used exclusively for the resident, which must be authorized in writing. The individuals who can authorize such transactions may be the resident, his/her legal guardian, or a legal representative (who may not be an employee at the facility, including the administrator);--The resident trust bank account should have at least two facility personnel as check signers. One such person is the Administrator and the other(s) should be chosen at the discretion of the Administrator. However, no one who handles the petty cash box, the checkbook, the posting of transactions, or assists residents in shopping for personal items should be a signer on the account; -Making Withdrawals from the Resident Trust Account:-- All checks written out of the trust account should be prepared by the Resident Trust Clerk and signed by the Administrator or other designated signer and should always be accompanied by a check request or other supporting documentation. All checks written out of the resident trust account should be copied prior to deposit or disbursement and attached to the appropriate documentation;--The checkbook balance should be updated each time a check is written. Deposits must also be entered into the checkbook;--Family members or friends who do not have legal access to a resident's account but wish to purchase clothing or personal items for a resident can do one of the following:1. Purchase the items needed and bring in the receipts to the Resident Trust Clerk. The clerk will then verify that a) the resident requested the items by signing the check request form and b) the resident has sufficient funds to reimburse the purchases.2. Have the resident sign a check request form to make the check payable to the individual wanting to purchase the items. The Resident Trust Clerk must verify the funds are available before writing the check. -Resident Trust Petty Cash:--The facility will maintain a resident petty cash fund for resident trust transactions only. The petty cash clerk will be a facility employee designated by the Administrator at each facility. The petty cash clerk will be someone other than the Resident Trust clerk and the Administrator and will not be authorized to sign checks. Requests for amounts larger than fifty dollars ($50) should be directed to the Resident Trust Clerk;--When a resident requests a cash withdrawal from his/her personal funds, the petty cash clerk will first verify the funds are available. This is to be done by (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	obtaining an Open Balance report from the Resident Trust Clerk;-- A three part withdrawal receipt must be completed at the time of disbursement. The receipt should list the resident's name, date, amount of withdrawalal, and the person disbursing the funds. The resident must sign the receipt. If the resident is unable to sign or can only mark an X, the receipt must be signed by two (2) facility staff members;--The petty cash clerk gives the resident the original receipt and the two duplicates are kept in the petty cash box;--On a daily basis usually at the end of the day, the Resident Trust clerk must enter into PCC all transactions into and out of the petty cash box;--When the petty cash box needs to be replenished the Resident Trust clerk must reconcile the cash left in the box with PCC;--The Resident Trust Clerk will file a copy of the check in the monthly Resident Trust file for the month for audit. -Resident Statements:--A detailed written account of all transactions affecting each resident's trust account shall be maintained and made available upon request.--The Resident Trust Clerk is responsible for sending out quarterly statements to the resident and his/her guardian or legal representative;--Make copies of all statements and date stamp them with the date they were mailed. Resident Trust Clerk will complete and sign the mailing confirmation and present to administrator to sign before emailing to Director of Business office. Review of the facility's Resident Rights policy, last reviewed on 9/21/25, showed:-Purpose: To ensure that resident rights are protected;-Protection of Resident Funds:--Accounting and Records. Facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to Facility on Resident's behalf. 1. Review of Resident # 6's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/31/26, showed:-Diagnoses included Alzheimer's disease, Parkinson's disease with dyskinesia (involuntary, erratic and uncontrollable movements), schizophrenia (a chronic and severe brain disorder that affects a person's ability to interpret reality, think logically, manage emotions and relate to others);-Cognition moderately impaired. Review of Resident's Patient Trust (PT) ledger, dated 5/1/25 through 3/20/26, showed:-Withdrawals from 5/1/25 through 7/8/25 were in dollars range of four to five dollars;-Withdrawals from 7/9/25 through 3/16/26 showed an increase in larger withdrawals ranging $24 to $40. Review of Resident's PT withdrawal receipts, showed:-Receipt #0251102, dated 7/28/25, for $34, was missing a resident signature;-Receipt #374127, dated 8/15/25, for five dollars and #251128, dated 1/30/26, for $35 showed inaccurate resident signature;-Receipt #251007, dated 1/27/26, showed in the numeric box $4 scratched out and replaced with $35 and written line amount four was crossed out and replaced with thirty-five;-Receipt #537690, dated 2/19/26, showed discrepancies in the resident name and no detail for the withdrawal of $30;-Discrepancies in handwriting located in the numeric box and the written line amount for the following receipts: --Receipt #117102, dated 10/25/25, was altered from $4 to $34;--Receipt #117021, dated 10/29/25, was altered from $4 to $24;--Receipt #117102, dated 10/25/25, was altered from $4 to $34;--Receipt #123279, dated 11/6/25, was altered from $4 to $24;--Receipt #133280, dated 11/14/25, was altered from $4 to $34;--Receipt #121113, dated 11/20/25, was altered from $4 to $34;--Receipt #132608, dated 11/21/25, was altered from $4 to $34;--Receipt #122609, dated 12/3/25, was altered from $4 to $34;--Receipt #122677, dated 12/4/25, was altered from $4 to $34;--Receipt #127002, dated 12/10/25 was altered from $4 to $34;--Receipt #127065, dated 12/11/25, was altered from $4 to $34;--Receipt #127116, dated 12/12/25, was altered from $4 to $34--Receipt #116605, dated 12/15/25, was altered from $4 to $34;--Receipt #122801, dated 12/22/25, was altered from $4 to $34;--Receipt #451115, dated 1/15/26, was altered from $4 to $34;--Receipt #451227, dated 1/19/26, was altered from $4 to $24;--Receipt #250531, dated 1/20/26, was altered from $4 to $34;--Receipt #451253, dated 1/22/26, was altered from $4 to $34;--Receipt #116917, dated 1/23/26, was altered from $4 to $34;--Receipt #251045, dated 1/28/26, was altered from $5 to $35;--Receipt #251104, dated 1/29/26, was altered from $4 to $24;--Receipt #251146, dated 2/2/26, was altered from $4 to $34;--Receipt #122979, dated 2/3/26, was altered from $4 to $34;--Receipt #537613, dated 2/18/26, was altered from $4 to $34;--Receipt #537690, dated 2/19/26, (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was altered from $4 to $34;--Receipt #537701, dated 2/20/26, was altered from $4 to $24;--Receipt #537805, dated 2/26/26, was altered from $4 to $34;--Receipt #534809, dated 3/3/26, was altered from $4 to $40;--Receipt #334809, dated 3/4/26, was altered from $3 to $34;--Receipt #334862, dated 3/5/26, was altered from $4 to $34;--Receipt #334907, dated 3/6/26, was altered from $4 to $34;--Receipt #516803, dated 3/9/26, was altered from $4 to $34;--Receipt #516876, dated 3/10/26, was altered from $4 to $34;--Receipt #517012, dated 3/13/26, was altered from $4 to $34; 2. Review of Resident # 8's quarterly MDS, dated [DATE], showed:-Diagnoses included Alzheimer's disease with early onset, schizophrenia, cognitive communication deficit;-Intact cognition. Review of Resident's PT ledger, dated 5/1/25 through 3/20/26, showed:-Withdrawal dated 11/6/25 in the amount of $36.00 had no receipts to verify withdrawal;-Withdrawal dated 11/28/25 in the amount of $36.00 had no receipts to verify withdrawal;-Withdrawal dated 12/4/25 in the amount of $35 had no receipts to verify withdrawal;-Withdrawal dated 12/8/25 in the amount of $25.00 had no receipts to verify withdrawal;-Withdrawal dated 12/12/25 in the amount of $36.00 had no receipts to verify withdrawal;-Withdrawal dated 12/15/25 in the amount of $35.00 had no receipts to verify withdrawal;-Withdrawal dated 12/19/25 in the amount of $36.00 had no receipts to verify withdrawal;-Withdrawal dated 12/22/25 in the amount of $35.00 had no receipts to verify withdrawal;-Withdrawal dated 12/30/25 in the amount of $35.00 had no receipts to verify withdrawal;-Withdrawal dated 12/31/25 in the amount of $35.00 had no receipts to verify withdrawal;-Withdrawal dated 1/2/26 in the amount of $36.00 had no receipts to verify withdrawal;-Withdrawals dated 1/5/26 through 1/9/26, totaled in the amount of $146.00 had no receipts to verify withdrawals;-Withdrawal dated 1/13/26 in the amount of $25.00 had no receipts to verify withdrawal;-Withdrawal dated 1/15/26 in the amount of $45.00 had no receipts to verify withdrawal;-Withdrawal dated 1/16/26 in the amount of $26.00 had no receipts to verify withdrawal;-Withdrawal dated 1/19/26 in the amount of $35.00 had no receipts to verify withdrawal;-Withdrawal dated 1/21/26 in the amount of $35.00 had no receipts to verify withdrawal;-Withdrawals dated 1/22/26 through 2/3/26, totaled in the amount of $303.00 had no receipts to verify withdrawals;-Withdrawal dated 2/4/26 in the amount of $35.00 had no receipts to verify withdrawal;-Withdrawal dated 2/6/26 in the amount of $26.00 had no receipts to verify withdrawal;-Withdrawals dated 2/13/26 through 2/24/26, totaled in the amount of $177.00 had no receipts to verify withdrawals;-Withdrawal dated 2/26/26 in the amount of $25.00 had no receipts to verify withdrawal;-Withdrawal dated 2/27/26 in the amount of $26.00 had no receipts to verify withdrawal;-Withdrawal dated 3/1/26 in the amount of $35.00 had no receipts to verify withdrawal;-Withdrawals dated 3/3/26 through 3/10/26, totaled in the amount of $180.00 had no receipts to verify withdrawals;-Withdrawal dated 3/12/26 in the amount of $35.00 had no receipts to verify withdrawal;-Withdrawal dated 3/13/26 in the amount of $36.00 had no receipts to verify withdrawal. Review of Resident's PT withdrawal receipts, showed:-Discrepancies in handwriting located in the numeric box and the written line amount for the following receipts: --Receipt #121019, dated 11/18/25, was altered from $4 to $35; $4 in the numeric box and four in written line amount were scratched out and replaced with $35 in numeric box and thirty-five in written line amount;--Receipt #121129, dated 11/20/25, was altered from $5 to $25. 3. Review of Resident #11 quarterly MDS), dated [DATE], showed:-Diagnoses included schizoaffective disorder, bipolar disorder (a mental health condition characterized by dramatic shifts in mood);-Intact cognition. Review of Resident's PT ledger, dated 5/1/25 through 3/20/26 showed:-Withdrawal dated 7/29/25 in the amount of $300.00 had no receipts to verify withdrawal;-Withdrawal dated 1/15/26 in the amount of $300.00 had no receipts to verify withdrawal. 4. Review of Resident #14 's quarterly MDS, dated [DATE], showed:-Diagnoses included schizophrenia;-Intact cognition. Review of Resident's PT withdrawal receipts, showed:--Receipt #122913, dated 12/24/25, in the amount of $27; not signed by resident;--Receipt #374012, dated 8/12/25, in the amount of $27; not signed by resident;--Receipt #846141, dated 7/16/25, in the amount of $27; not signed by resident;--Receipt #0251031, dated (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7/24/25, in the amount of $29; not signed by resident;--Receipt #374012, dated 8/12/25, in the amount of $27; not signed by resident;--Receipt #606767, dated 9/15/25, in the amount of $25; not signed by resident;--Receipt #0059798, dated 9/22/25, in the amount of $45; not signed by resident;--Receipt #606767, dated 10/29/25, in the amount of $27; not signed by resident;--Receipt #126857, dated 1/5/26, in the amount of $27; not signed by resident;--Receipt #321310, dated 1/6/26, in the amount of $29; not signed by resident;--Receipt #251256, undated, in the amount of $27; not signed by resident;--Receipt #251317, dated 1/9/26, in the amount of $27; not signed by resident;--Receipt #451095, dated 1/15/26, in the amount of $27; not signed by resident;--Receipt #451216, dated 1/19/26, in the amount of $27; not signed by resident;--Receipt #250544, dated 1/20/26, in the amount of $27; not signed by resident;--Receipt #250593, dated 1/21/26, in the amount of $27; not signed by resident;--Receipt #116982, dated 1/26/26, in the amount of $27; signature section blank;--Receipt #251016, dated 1/27/26, in the amount of $27; not signed by resident;--Receipt #251147, dated 2/2/26, in the amount of $27; not signed by resident;--Receipt #122980, dated 2/3/26, in the amount of $27; not signed by resident;--Receipt #537614, dated 2/3/26, in the amount of $27; not signed by resident;--Receipt #977891, dated 2/17/26, in the amount of $27; not signed by resident;--Receipt #537614, dated 2/18/26, in the amount of $27; not signed by resident;--Receipt #537693, dated 2/19/26, in the amount of $27; signature section blank;--Receipt #537703, dated 2/20/26, in the amount of $27; not signed by resident;--Receipt #337921, dated 2/25/26, in the amount of $27; not signed by resident;--Receipt #537806, dated 2/26/26, in the amount of $27; not signed by resident;--Receipt #537845, dated 2/27/26, in the amount of $27; not signed by resident;--Receipt #337811, dated 2/28/26, in the amount of $27; not signed by resident.-Discrepancies in handwriting located in the numeric box and the written line amount for the following receipts: --Receipt #117116, dated 10/20/25, was altered from $7 to $27;--Receipt #121126, dated 11/20/25, was altered from $7 to $27;--Receipt #116853, undated, was altered from $7 to $27;--Receipt #122863, dated 12/23/25, was altered from $7 to $27. 5. Review of Resident #17 's quarterly MDS, dated [DATE], showed:-Diagnoses included psychotic disorder with delusions due to unknown physiological condition, schizophrenia unspecified;-Intact cognition. Review of the resident's Patient Trust (PT) ledger, dated 5/31/25 through 3/16/26, showed:-Withdrawal dated 10/8/25 in the amount of $50.00 had no receipts to verify withdrawal;-Withdrawal dated 1/23/26 in the amount of $400.00 had no receipts to verify withdrawal. Review of Resident's Post Shopping form copy, dated 10/8/25, showed:-Staff complete: Business Office Manager;-List of items purchased: were blank;-Section listed: Cash from resident: $650.00; showed was altered; with a written note showed $500 gift card and $150 cash was used in transaction;-Total Spent: $439.57; Total Change: $210.43; Change given to resident: was marked with an X, with a handwritten note that said: But has more shopping request so $150.00 will be used toward shopping; no receipt to verify purchases were made with the $150.00;-Resident signature: showed resident signed;-Staff signature: Business Office Manager;-Included one receipt:--Walmart dated 11/4/25, in the amount of $368.64 that showed a purchase of iphone 13, screen protector, phone case; resident was given an Android [NAME]-phone. 6. Review of Resident # 27's Quarterly MDS, dated , 2/28/26, showed:-Diagnoses included schizophrenia, antisocial personality disorder;-Intact cognition. Review of the resident's Patient Trust (PT) ledger, dated 5/31/25 through 3/16/26, showed:-Withdrawal dated 10/22/25 in the amount of $400.00 showed discrepancies with gift card purchase;-Withdrawal dated 11/18/25 in the amount of $200.00 had no receipts to verify withdrawal;-Withdrawal dated 12/1/25 in the amount of $250.00 had no receipts to verify withdrawal;-Withdrawal dated 12/16/25 in the amount of $250.00 had no receipts to verify withdrawal;-Withdrawal dated 2/24/26 in the amount of $400.00 had no receipts to verify withdrawal;-Withdrawal dated 3/5/26 in the amount of $400.00 had no receipts to verify withdrawal. Review of Resident's store receipts, showed:-On 10/22/25, three gift cards from Dollar Tree were purchased in the amounts of $150.00, $300.00, and $100.00 totaled in the amount of $550.00; location of gift cards unknown;-On 10/23/25, Walmart receipt in the of $55.96, showed resident did not (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	acknowledge purchase. Review of Resident's Post Shopping form copy, undated, showed:-Staff complete: Business Office Manager;-List of items purchased: were blank;-Section listed: Cash from resident: $300.00; Total Spent: $267.91; Total Change: $32.09; Change given to resident;-Staff signature: Business Office Manager;-Included two receipts:--Walmart dated 1/30/26, in the amount of $141.06 that showed a purchase of Airpods 4;--Walmart dated 1/4/26, was unreadable for the amount and purchase detail. Review of Resident's computer withdrawal receipt, dated 1/16/26, showed the amount of $600.00 had no receipts to verify purchases. 7. Review of Resident #35 's quarterly MDS, dated [DATE], showed:-Diagnoses included schizophrenia, social phobia unspecified;-Intact cognition. Review of Resident's PT withdrawal receipts, showed:-Receipt #032123, dated 7/9/25, for $24, altered resident signature and incomplete receipt detail;-Receipt #846090, dated 7/15/25, for $26, altered resident signature and incomplete receipt detail;-Receipt #305412, dated 7/31/25, for $35, altered resident signature.-Discrepancies in handwriting located in the numeric box and the written line amount for the following receipts: --Receipt #117046, dated 10/29/25, was altered from $4 to $34;--Receipt #123304, dated 11/7/25, was altered from $4 to $34;--Receipt #121133, dated 11/20/25, was altered from $4 to $34;--Receipt #132745, dated 11/28/25, was altered from $4 to $34;--Receipt #127025, dated 12/10/25, was altered from $4 to $24;--Receipt #122961, dated 12/24/25, was altered from $5 to $35;--Receipt #116801, dated012/30/25, was altered from $4 to $34. 8. Review of Resident # 38's quarterly MDS, dated [DATE], showed:-Diagnoses included schizophrenia, major depressive disorder;-Intact cognition. Review of Resident's PT ledger, dated 5/1/25 through 3/20/26 showed:-Withdrawal dated 8/12/25 in the amount of $20.00 had no receipts to verify withdrawal;-Withdrawal dated 8/18/25 in the amount of $15.00 had no receipts to verify withdrawal;-Withdrawal dated 8/26/25 in the amount of $20.00 had no receipts to verify withdrawal;-Withdrawal dated 9/2/25 in the amount of $10.00 had no receipts to verify withdrawal;-Withdrawal dated 9/15/25 in the amount of $45.00 had no receipts to verify withdrawal;-Withdrawals dated 10/27/25 through 10/30/25, totaled in the amount of $90.00 had no receipts to verify withdrawal;-Withdrawal dated 11/14/25 in the amount of $35.00 had no receipts to verify withdrawal;-Withdrawal dated 11/19/25 in the amount of $5.00 had no receipts to verify withdrawal;-Withdrawal dated 11/21/25 in the amount of $25.00 had no receipts to verify withdrawal;-Withdrawal dated 11/28/25 in the amount of $25.00 had no receipts to verify withdrawal;-Withdrawals dated 12/4/25 through 12/5/25, totaled in the amount of $50.00 had no receipts to verify withdrawals;-Withdrawals dated 12/11/25 through 12/12/25, totaled in the amount of $50.00 had no receipts to verify withdrawals;-Withdrawals dated 12/16/25 through 12/30/25 totaled in the amount of $195.00 had no receipts to verify withdrawals;-Withdrawals dated 1/2/26 through 1/9/26 totaled in the amount of $180.00 had no receipts to verify withdrawals;-Withdrawal dated 1/13/26 in the amount of $25.00 had no receipts to verify withdrawal;-Withdrawals dated 1/15/26 through 1/19/26, totaled in the amount of $105.00 had no receipts to verify withdrawals;-Withdrawal dated 1/21/26 in the amount of $35.00 had no receipts to verify withdrawal; -Withdrawals dated 1/26/26 through 1/30/26, totaled in the amount of $140.00 had no receipts to verify withdrawals;-Withdrawal dated 2/3/26 in the amount of $5.00 had no receipts to verify withdrawal;-Withdrawal dated 2/19/26 in the amount of $15.00 had no receipts to verify withdrawal;-Withdrawal dated 2/23/26 in the amount of $25.00 had no receipts to verify withdrawal;-Withdrawal dated 2/25/26 in the amount of $25.00 had no receipts to verify withdrawal. Review of Resident's PT withdrawal receipts, showed:-Discrepancies in handwriting located in the numeric box and the written line amount for the following receipts: --Receipt #846162, dated 7/16/25, was altered from $4 to $24;--Receipt #117038, dated 10/29/25, was altered from $5 to $35. 9. Review of Resident # 41's comprehensive MDS, dated [DATE], showed:-Diagnoses included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, schizoaffective disorder bipolar type;-Cognition moderately impaired. Review of Resident's PT ledger, dated 5/1/25 through 3/20/26, showed:-Withdrawal dated 5/27/25, (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	in the amount of $36.00, has no receipt to verify withdrawal;-Two Withdrawals dated 6/30/25, in the amount of $45.00 each, has no receipt to verify withdrawals;-Withdrawal dated 7/1/25, in the amount of $500.00, has no receipt to verify withdrawal;-Withdrawal dated 8/11/25 in the amount of $800.00 had no receipts to verify withdrawal;-Withdrawal dated 8/12/25 in the amount of $35.00 had no receipts to verify withdrawal;-Withdrawal dated 8/19/25 in the amount of $35.00 had no receipts to verify withdrawal;-Withdrawals dated from 10/22/25 through 10/23/26 totaling in the amount of $90.00 had no receipts to verify withdrawals; -Withdrawals dated from 10/27/25 through 10/30/26 totaling in the amount of $128.00 had no receipts to verify withdrawals;-Withdrawals dated from 11/13/25 in the amount of $100.00 had no receipts to verify withdrawal;-Withdrawals dated from 11/18/25 in the amount of $45.00 had no receipts to verify withdrawal;-Withdrawals dated from 11/20/25 through 11/21/25 totaling in the amount of $70.00 had no receipts to verify withdrawals;-Withdrawals dated from 12/3/25 through 12/4/25 totaling in the amount of $80.00 had no receipts to verify withdrawals;-Withdrawals dated from 12/16/25 in the amount of $300.00 had no receipts to verify withdrawal;-Withdrawals dated from 12/17/25 through 3/13/26 totaling in the amount of $1075.00 had no receipts to verify withdrawals. Review of Resident PT withdrawal receipts showed:-Receipt #176678, dated 7/7/25, for $45, missing resident signature;-Receipt #0348128, dated 7/8/25, for $45, missing resident signature;-Receipt #621107, dated 7/21/25, for $45, missing resident signature;-Receipt #621149, dated 7/22/25, for $45, missing resident signature;--Receipt #032118, dated 7/9/25, for $45; receipt wasn't filled out completely - amount disputed;-Discrepancies in handwriting located in the numeric box and the written line amount for the following receipts: --Receipt #621023, dated 7/17/25, was altered from $5 to $45 and inaccurate resident signature. During an interview on 4/28/26 at 10:10 A.M., the resident said he/she did not withdrawal more than four to five dollars each time except when he/she purchased cigarettes. The resident said he/she did not remember withdrawing $500.00 to go shopping, but would like to go if someone would take him/her. 10. Review of Resident # 42's quarterly MDS, dated [DATE], showed: -Diagnoses included schizophrenia;-Intact cognition. Review of Resident's PT ledger, dated 5/1/25 through 3/20/26, showed:-Withdrawal dated 6/2/25 in the amount of $10.00 had no receipt to verify withdrawal;-Withdrawal dated 7/1/25 in the amount of $400.00 had no receipt to verify withdrawal. 11. Review of Resident # 47's quarterly MDS, dated [DATE], showed:-Diagnoses included mild intellectual disabilities, personal history of traumatic brain injury, cognitive communication deficit, paranoid schizophrenia;-Cognition severely impaired. Review of Resident's PT ledger, dated 5/1/25 through 3/20/26, showed:-Withdrawal dated 6/24/25 in the amount of $500.00 had no receipt to verify withdrawal;-Withdrawal dated 11/18/25 in the amount of $33.00 had no receipt to verify withdrawal;-Withdrawal dated 12/1/25 in the amount of $35.00 had no receipt to verify withdrawal;-Withdrawal dated 12/3/25 in the amount of $23.00 had no receipt to verify withdrawal;-Withdrawal dated 12/8/25 in the amount of $23.00 had no receipt to verify withdrawal;-Withdrawal dated 12/9/25 in the amount of $24.00 had no receipt to verify withdrawal;-Withdrawal dated 12/15/25 in the amount of $23.00 had no receipt to verify withdrawal;-Withdrawal dated 12/19/25 in the amount of $24.00 had no receipt to verify withdrawal;-Withdrawal dated 12/24/25 in the amount of $23.00 had no receipt to verify withdrawal;-Withdrawal dated 12/30/25 in the amount of $33.00 had no receipt to verify withdrawal;-Withdrawal dated 1/8/26 in the amount of $23.00 had no receipt to verify withdrawal;-Withdrawal dated 1/26/26 in the amount of $24.00 had no receipt to verify withdrawal;-Withdrawal dated 1/27/26 in the amount of $24.00 had no receipt to verify withdrawal;-Withdrawal dated 1/29/26 in the amount of $24.00 had no receipt to verify withdrawal;-Withdrawal dated 2/2/26 in the amount of $34.00 had no receipt to verify withdrawal;-Withdrawal dated 2/6/26 in the amount of $24.00 had no receipt to verify withdrawal;-Withdrawal dated 2/17/26 in the amount of $24.00 had no receipt to verify withdrawal;-Withdrawal dated 3/4/26 in the amount of $34.00 had no receipt to verify (continued on next page)

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	265823	A. Building B. Wing	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestwood Health Care Center, LLC	11400 Mehl Avenue Florissant, MO 63033

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	withdrawal;-Withdrawal dated 3/5/26 in the amount of $34.00 had no receipt to verify withdrawal;-Withdrawal dated 3/9/26 in the amount of $300.00 had no receipt to verify withdrawal;-Withdrawal dated 3/10/26 in the amount of $24.00 had no receipt to verify withdrawal;-Withdrawal dated 3/13/26 in the amount of $24 had no receipt to verify withdrawal. 12. Review of Resident # 52's quarterly MDS, dated [DATE], showed:-Diagnoses included schizoaffective disorder, bipolar type, autistic disorder;-Intact cognition. Review of Resident's PT ledger, dated 5/1/25 through 3/20/26, showed a withdrawal dated 1/22/26 in the amount of $29.00 had no receipt to verify withdrawal. 13. Review of Resident # 54's quarterly, MDS, dated [DATE], showed:-Diagnoses included bipolar disorder unspecified, autistic disorder;-Intact cognition. Review of Resident's PT ledger, dated 5/1/25 through 3/20/26, showed:-Withdrawal dated 12/16/25 in the amount of $200.00 had no receipts to verify withdrawal;-Withdrawal dated 10/22/25 in the amount of $34.00 had no receipts to verify withdrawal;-Withdrawal dated 10/30/25 in the amount of $ 34.00 had no receipts to verify withdrawal;-Withdrawal dated 11/18/25 in the amount of $44.00 had no receipts to verify withdrawal;-Withdrawal dated 11/21/25 in the amount of $24.00 had no receipts to verify withdrawal;-Withdrawal dated 11/28/25 in the amount of $34.00 had no receipts to verify withdrawal;-Withdrawal dated 12/5/25 in the amount of $24.00 had no receipts to verify withdrawal;-Withdrawals dated from 12/11/25 through 1/6/26 totaling in the amount of $204.00 had no receipts to verify withdrawals;-Withdrawals dated from 1/13/26 through 1/16/26 totaling in the amount of $106.00 had no receipts to verify withdrawals;-Withdrawal dated 1/22/26 in the amount of $34.00 had no receipts to verify withdrawal;-Withdrawals dated from 1/27/26 through 1/30/26 totaling in the amount of $97.00 had no receipts to verify withdrawals; -Withdrawal dated 2/4/26 in the amount of $24.00 had no receipts to verify withdrawal;-Withdrawals dated from 2/13/26 through 2/17/26 totaling in the amount of $49.00 had no receipts to verify withdrawals;-Withdrawals dated from 2/25/26 through 3/3/26 totaling in the amount of $123.00 had no receipts to verify withdrawals;-Withdrawals dated from 3/5/26 through 3/6/26 totaling in the amount of $48.00 had no receipts to verify withdrawals;-Withdrawal dated 3/10/26 in the amount of $25.00 had no receipts to verify withdrawal. Review of Resident's PT withdrawal receipts showed:-Discrepancies in handwriting located in the numeric box and the written line amount for the following receipts: --Receipt #123295, dated 11/7/25, was altered from $4 to $44;--Receipt #122713, dated 12/4/25, was altered from $4 to $24;--Receipt #132827, dated 12/5/25, was altered from $4 to $24;--Receipt #132895, dated 12/8/25, was altered from $4 to $24. 14. Review of Resident # 56's quarterly MDS, dated [DATE], showed:-Diagnoses included cerebellar stroke syndrome, schizophrenia unspecified;-Cognition moderately impaired. Review of Resident's PT ledger, dated 1/1/25 through 3/31/26, showed:-Withdrawal dated 7/31/25 in the amount of $35.00 had no receipts to verify withdrawal;-Withdrawal dated 8/19/25 in the amount of $25.00 had no receipts to verify withdrawal;-Withdrawal dated 1/19/26 in the amount of $34.00 had no receipts to verify withdrawal. 15. Review of Resident # 60's quarterly MDS, dated [DATE], showed:-Diagnoses included paranoid schizophrenia, unspecified intellectual disabilities;-Intact cognition. Review of Resident's PT ledger, dated 5/1/25 through 3/20/26, showed:-Withdrawal dated 7/28/25 in the amount of $34.00 had no receipts to verify withdrawal;-Withdrawal dated 9/5/25 in the amount of $30.00 had no receipts to verify withdrawal;-Withdrawal dated 10/6/25 in the amount of $25.00 had no receipts to verify withdrawal;-Withdrawal dated 10/29/25 in the amount of $35.00 had no receipts to verify withdrawal;-Withdrawal dated 10/30/25 in the amount of $25.00 had no receipts to verify withdrawal;-Withdrawal dated 11/6/25 in the amount of $35.00 had no receipts to verify withdrawal;-Withdrawal dated 11/14/25 in the amount of $25.00 had no receipts to verify withdrawal;-Withdrawal dated 11/18/25 in the amount of $25.00 had no receipts to verify withdrawal;-Withdrawal dated 11/20/25 in the amount of $25.00 had no receipts to verify withdrawal;-Withdrawal dated 11/21/25 in the amount of $25.00 had no receipts to verify withdrawal;-Withdrawal dated 12/3/25 in the amount of $25.00 had no receipts to verify (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	withdrawal;-Withdrawal dated 12/4/25 in the amount of $35.00 had no receipts to verify withdrawal;-Withdrawal dated 12/8/25 in the amount of $25.00 had no receipts to verify withdrawal;-Withdrawal dated 12/15/25 in the amount of $25.00 had no receipts to verify withdrawal;-Withdrawal dated 12/16/25 in the amount of $25.00 had no receipts to verify withdrawal;-Withdrawal dated 12/19/25 in the amount of $35.00 had no receipts to verify withdrawal;-Withdrawals dated from 12/23/25 through 1/2/26 totaling in the amount of $100.00 had no receipts to verify withdrawals;-Withdrawals dated from 1/5/26 through 1/15/26 totaling in the amount of $250.00 had no receipts to verify withdrawals;-W

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure staff provided adequate supervision when one resident (Resident #78) eloped from the facility at approximately 6:00 A.M. and staff were not aware the resident was missing until they received notification from a hospital that the resident arrived to the hospital at 8:06 A.M. The facility failed to ensure staff responded appropriately and in accordance with facility policy when one resident (Resident #63) pulled the fire alarm. The sample was 31. The census was 141.Review of the facility's Fire Alarm Pulls and Risk for Elopement Response policy, undated, showed:-Purpose: To ensure the safety of all residents by providing clear procedures for staff response when a fire alarm is pulled, including immediate actions to identify potential elopement and ensure all residents are accounted for;-Immediate actions when a fire alarm is pulled:--Check the fire alarm panel immediately;--Staff must go to the panel immediately to identify which pull station or zone was activated;--Respond to the location identified on the panel;--Staff must immediately go to the exact location of the activated pull station to determine if there is an active fire or hazard;--One staff must immediately exit the door closest to the activated pull station and walk the exterior perimeter of the facility in that area, look for any resident who may have exited the building, and report finding immediately to the charge nurse;--Remaining staff will follow standard fire response procedures;--Nursing staff must initiate an immediate headcount: Staff must physically lay eyes on residents-not just check rooms and confirm that all residents are accounted for;--If any resident is not accounted for and no resident is located during the exterior sweep and nursing confirms a resident is missing during the headcount: The Code [NAME] (missing person) policy must be implemented immediately. This includes facility wide notification, initiation of search procedure per policy and notification of administrator and additional parties;--Important reminders: Fire alarms are not only a fire risk-they are also an elopement risk. Every alarm must be treated as a potential missing resident event until proven otherwise. Delays in response can result in serious harm. Review of the facility's Elopements and Wandering Residents policy, dated last reviewed 6/12/24, showed:-The facility is equipped with door locks/alarms to help avoid elopements;-Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner;-Adequate supervision will be provided to help prevent accidents or elopements;-Any staff member becoming aware of a missing resident will alert personnel using facility approved protocol:--Code [NAME] = Elopement from facility;--The designated facility staff will look for the resident;--If the resident is not located in the building or on the grounds, Administrator or designee will notify the police department and serve as the designated liaison between the facility and the police department. The administrator or designee should also notify the company's corporate office. 1. Review of Resident #78's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/3/26, showed:-Cognitively intact;-No behaviors exhibited;-Diagnoses included Alzheimer's disease, depression, bipolar disorder (mood disorder with extreme moods swings), psychotic disorder, schizophrenia (serious mental illness that affects how a person thinks, feels, and behaves), and schizoaffective disorder bipolar type (mental health condition that is marked by a mix of schizophrenia symptoms and mood disorder symptoms). Review of the resident's care plan, in use at the time of the survey, showed:-Problem, dated 4/13/26: Resident eloped from 100 hall;-Goal: Resident will not elope through next review;-Intervention: Resident placed on 600 hall. Elopement assessment updated and picture placed in the book. Social Services (SS) to meet with resident daily to assist with decreasing anxiety related to his/her delusions;-Problem, dated 4/14/26: Resident is at risk of elopement due to history of elopement from prior secure facility and/or expresses a desire to elope from facility;-Goal: The Resident will not elope from facility through next review;-Interventions: Complete elopement assessment on admission, readmission and (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	quarterly. Face checks will be completed by facility protocol. Resident's photo and information will be kept in elopement book. Review of the resident's progress note, dated 4/13/26 at 2:51 P.M., showed elopement. Patient last seen at approximately 7:00 A.M. At 12:30 P.M., receptionist brought to the nurse's attention the hospital had called and needed information on the resident that had arrived there. Director of Nurses (DON) and Administrator notified immediately. A thorough search of the unit and facility grounds was initiated immediately. Resident then noted absent from the facility. The hospital representative said the resident had arrived there at 8:06 A.M., after being picked up by emergency medical services (EMS) and transported to the hospital. Resident was evaluated while there and was diagnosed with schizoaffective disorder, which is already specified as a prior diagnosis in his/her medical history. Patient arrived back at the facility at 2:10 P.M. An initial head-to-toe assessment performed. No visible injuries. Mental status and range of motion within normal limits according to prior assessments. Resident asked once how did you get out? Resident stated that he/she had gone out of 400 hall's door. During an interview on 4/27/26 at 11:04 A.M., the resident said he/she waited for the nurse to get busy and when there were a lot of people around, he/she exited the building out the 400 hall door. The door made a sound when it opened. He/She walked to the bus terminal and got an ambulance to take him/her to the hospital. Review of the facility's investigation, dated 4/14/26, showed:-Date and approximate time of incident: 4/14/26 at 12:30 P.M.-Type of incident: Elopement;-Investigative narrative report: The receptionist brought to the nurse's attention the hospital called and needed information on the resident. An immediate head count was started, and the resident was found to be not in the building. The hospital representative said the resident arrived at the hospital at 8:06 A.M. after being picked up by the ambulance at a transit station on a main road. Ambulance attendant stated resident requested to go to a specific hospital because he/she wanted to visit his/her family member and meet Saint [NAME]. Resident was evaluated while at the hospital. Patient arrived back at the facility at 2:10 P.M. Resident asked once he/she returned to facility how did you get out? Resident stated that he/she had gone out of 400 hall's door. Stated he/she wanted to visit his/her family at the hospital. Interview with multiple staff members and residents. Resident was last seen around 6:00 A.M. at the nurse station;-Conclusion/outcome of the investigation: Allegation substantiated. Review of the typed interviews completed by the Administrator, undated, showed:-The Administrator interviewed the day shift aides on the 100 hall: Certified Nurse Aide (CNA) I, CNA J, and CNA K. All three CNAs stated they did not see the resident when they did rounds, but they did not tell the nurse because they just assumed the resident was in the hospital;-Day shift Certified Medication Technician (CMT), CMT L, said he/she did not see the resident;-Licensed Practical Nurse (LPN) M interviewed three alert residents who were awake and at the nurse's station at the time of incident, said they did not hear the 400 hall door go off;-Night shift CNA N, said he/she was down by the laundry room on 4/13/26 at around 6:00 A.M., and did not hear the door alarm go off. During an interview on 4/30/26 at 11:29 A.M., CNA P said the resident was up all night long, he/she was combative, and he/she wanted to see his/her family member, who was in the hospital. At 6:00 A.M., CNA P took the residents out to smoke while the other aide provided care for the other residents. After the residents smoked, CNA P returned to the hall and assisted other residents with care. Between the hours of 6:00 A.M. and 6:30 A.M., all the alarms on all the halls start going off. If someone pushed the egress door bar for longer than three seconds, it would open. He/She did not realize the resident was not there when he/she returned to the hall. During an interview on 4/30/26 at 7:13 A.M. LPN O said two nurses work on the night shift. They tried to be sure one nurse was at the nurse's station. With the combination of all the staff, residents are rounded on every hour. If a resident was not in their room, between the hours of 11:00 P.M. and 5:00 A.M., he/she would ask other staff if they knew where the resident was. If they could not determine where the resident was, a head count would be done and the whole facility would be checked. If they still could not find the resident, they would notify the Administrator and police. Between the hours of 5:00 A.M. and 7:00 A.M., the residents are beginning to move about. On 4/13/26, he/she was not assigned to the 100 (continued on next page)

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If they could not find the resident, he/she would notify the Administrator. At around 6:00 A.M., all the alarms start going off because the residents come out into the common areas and go out to smoke. The door on the 400 hall will open if the egress bar is pushed/held for 15 seconds. LPN E worked the night shift and the day shift. The CNAs did not report the resident was missing or the resident missed breakfast. He/She did not know the resident was not in the facility until the receptionist reported the hospital called and wanted information on the resident. When the resident returned to the facility, the resident said he/she went out the 400 hall door. During an interview on 5/1/26 at 1:00 P.M., the DON said they found out the resident was not in the facility when the hospital called the facility. The resident left the facility around 6:00 A.M. and exited out the 400 hall door. The resident was looking for his/her family member. The door has an alarm on it. There were conflicting stories about whether the alarm sounded or not. When an alarm sounds, staff should go and see what is going on and they should check inside and outside looking to see if someone may have exited the building, and initiate a head count and do face checks. If a resident was unaccounted for, it should be reported. The Administrator said staff should check the alarms on the doors to be sure they are working. Staff should round on residents every two hours. The entire team completes face checks every two hours. Since there were conflicting stories about whether the alarm sounded or not when the resident eloped, an outside company came and checked the doors, and they were functioning. She expected staff to follow the facility's policies and procedures. 2. Review of Resident #63's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Other behavioral symptoms not directed towards others occurred 1 to 3 days;-Diagnoses included anxiety, depression, bipolar disorder), schizophrenia, Asperger syndrome (autism spectrum), mild intellectual disabilities, and borderline personality disorder (a mental health condition marked by extreme mood swings, impulsive behaviors, and unstable relationships). Review of the resident's care plan, in use at the time of survey, showed: -Problem: Resident has negative behaviors of breaking windows, pulling fire alarms, elopement, cutting, breaking back of toilet;-Goal: The resident an increase in positive behaviors through the review date;-Interventions included:--Coping skills: Blank;--Needed supports: Counseling, structured environment, alcohol abuse treatment, drug abuse treatment, outside support network, and coping skills training;--Resident's support system: Blank;--Triggers: Blank. Observation on 4/26/26 at 11:46 A.M., showed the fire alarm sounded. The Social Services Assistant (SSA) went to the fire panel and opened the case. The panel showed the alarm at room [ROOM NUMBER]. SSA pressed Silence on the panel and walked toward the 300 hall. When the SSA was approximately 10 feet from the fire panel, staff could be heard yelling, False alarm, it was a resident, he/she pulled the alarm. Approximately three staff members entered the 300 hall and went to the end of the hallway. Other staff on various hallways continued passing noon meal hall trays and passing medications, and did not cease activities to respond to the fire alarm. No overhead announcement made regarding the location of the triggered fire alarm. During an interview on 4/26/26 at 12:00 P.M., the SSA said when the fire alarm sounded, she went to the fire panel and hit the switch to silence the alarm. Then, she took the key to the 300 hall pull station. Once she got on the 300 hall, someone told her that a resident pulled the fire alarm, but she could not recall who told her this. She could tell by looking at the pull station the resident pulled the alarm. She called the front desk using her personal cell phone to notify them not to send out EMS/fire department. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/26/26 at 12:50 P.M., the Maintenance Director said he was in his office when he heard the fire alarm sound. He met the nurse with the key at the panel. No rounds were made because we knew the resident was acting out. The resident has set off the fire alarm five or six times since he has been at the facility, for about a month. During an interview on 4/26/26 at 1:15 P.M., the DON said the resident had a history of pulling the fire alarm. The resident was upset because he/she wanted his/her hair braided and the staff told the resident he/she would have to wait. He/She went back to his/her room, broke a light, and pulled the fire alarm. During an interview on 5/1/26 at 1:00 P.M., the Administrator said when the fire alarm sounded, the front desk should make an announcement as to where the location of the fire alarm was activated. She expected staff to follow the facility's policies and procedures and respond appropriately to the alarm. 29831052981901