| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265823 | A. Building<br>B. Wing | 05/22/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Crestwood Health Care Center, LLC | 11400 Mehl Avenue<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>Based on interview and record review, the facility failed to ensure one resident (Resident #1) was free from physical abuse when a Certified Nursing Assistant (CNA A) yelled and used profanity at the resident, then grabbed and pushed the resident to the ground. The sample size was four. The census was 141.The administrator was notified on 5/22/25, of the past non-compliance. The facility responded appropriately when the incident occurred. CNA A left the facility and resigned. A witness, CNA G, was terminated. The facility provided training and in-services for all staff regarding abuse and neglect, de-escalation techniques, tap-out procedure, and residents' rights. The deficiency was corrected on 5/20/26. Review of the facility's Resident's Rights policy, revised 9/21/25, showed:-Purpose: To ensure that resident rights are protected;-Resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. Facility must protect and promote rights of each resident, including each of the following rights;-Freedom from abuse: Resident has the right to be free from verbal, sexual, mental, and physical abuse, corporal punishment and involuntary seclusion. 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;-Verbal abuse: The use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability. This includes using profanity or speaking in demeaning, non-therapeutic, undignified, threatening or derogatory manner in a resident's presence;-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. Physical abuse includes handling a resident with any more force than is reasonable for a resident's proper control, treatment or management. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/9/26, showed:-Cognitively intact;-No hallucinations or delusions;-No rejection of care;-No impairment to both lower and upper extremities;-Diagnoses included seizure disorder, depression, and bipolar disorder (mental health condition that causes extreme shifts in mood, energy and activity levels). Review of the facility's investigation report, dated 5/20/26, showed:-Date and approximate time of incident: 5/20/26 at 11:55 A.M.,-Type of incident: Physical aggression involving head;-Persons involved: Resident #1 and CNA A;-Date and time notified: 5/20/26 at 1:00 P.M.;-A loud noise heard coming from 600 hall the writer went to investigate and saw Resident #1 sitting on floor, Indian style, stating that staff pushed him/her. CNA A had exited the building, resident stated he/she was calling his guardian. The resident said, CNA A told him/her to shut the fuck up. CNA A then grabbed the resident and pushed him/her to the ground. During an interview on 5/22/26 at 10:25 A.M., Licensed Practical Nurse (LPN) B said when he/she and Registered Nurse (RN) F responded to the loud noise behind 600 hall, Resident #1 was by the door, crying and told them that CNA A put his/her hands on him/her. CNA A quickly left the facility, and they were not able to ask questions. LPN B said he/she was not certain if Code [NAME] (code called<br>(continued on next page) |



| 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 |
|---|---|---|---|
| | 265823 | A. Building<br>B. Wing | 05/22/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Crestwood Health Care Center, LLC | 11400 Mehl Avenue<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | when a resident exhibiting aggressive behaviors) was called. He/She said it happened too fast. CNA A had already left the facility. LPN B never witnessed and was not aware of any history of CNA A being abusive and inappropriate to any residents. He/She did not observe CNA A being distracted or had signs of irritation. During an observation and interview on 5/22/26 at 10:44 A.M., the resident said on Wednesday, 5/20/26, sometime before lunch, CNA A put his/her hands on him/her and kept saying shut the fuck up. He/She said the CNA grabbed his/her shirt, almost choking him/her, and pushed him/her in the chest caused him/her to hit his/her head on the door. He/She was asking questions and did not know why the CNA became angry. Another staff member (CNA G) saw and heard CNA A yell at the resident but did not do anything. The resident said he/she had nightmares that night after the incident. He/She did not want the facility to report the incident to the police department. The resident showed a photo of his upper chest from his/her cellphone, showing some redness. The resident said there were no major injuries, and he/she was doing fine but did not want to see CNA A anymore. The resident said he/she was on the phone with his/her guardian during the incident and the guardian heard the staff yelling at the resident. During an interview on 5/22/26 at 11:13 A.M., CNA A said the resident was upset and restless that day, prior to the incident. He/She said another resident pulled the fire alarm, so the facility was doing resident headcounts and not allowing anybody to go out and smoke. Resident #1 did not like it when he/she was told of the situation and kept following the CNA around. The CNA said, I lost my cool, and pushed the resident. He/She denied choking the resident but grabbed his/her shirt in the chest area. He/She was aware of de-escalation techniques, proper approach to residents with behaviors, and was trained for abuse policy, and residents rights. He/She said he/she should have avoided the situation and let the nurse know instead of putting his/her hands on the resident. During an interview on 5/22/26 at 11:31 A.M., RN C said he/she expected the staff to report if residents were having behaviors. He/She would remind the staff how to de-escalate the situation and never hurt any resident. During altercations between staff and resident, RN C said he/she would expect staff to separate the individuals immediately, and the nurse to assess the resident, making sure the resident was safe from further injuries. During an interview on 5/22/26 at 11:47 A.M., CNA D said he/she had witnessed resident to resident altercation in the facility but no staff to resident altercations. He/She would de-escalate the situation by separating the individuals. He/She would call for help and not leave the residents, making sure residents were safe. Code [NAME] should be called. He/She would report the incident to the nurse immediately. During an interview on 5/22/26 at 11:59 A.M., CNA E said he/she would attempt to de-escalate the residents during increased behaviors. If the behaviors continued, he/she would call Code Green, and stay with the resident to avoid further behaviors and altercation. If being provoked by residents, he/she would walk away and let other staff know. He/She would report the situation to the nurse in charge. During an interview on 5/22/26 at 12:12 P.M., Social Services (SS) said that he/she heard a very loud noise. When he/she went to 600 hall, RN B and RN F had already responded. The resident was right by the door, standing up. When SS asked the staff, they said they did not see what happened. The resident said the staff choked him. SS said a staff said that the resident was on CNA A's face prior to the physical contact. SS expected the staff to know when to tap out when residents had increased behaviors. SS expected staff to avoid altercation with residents and remember their trainings on de-escalation techniques. During an interview on 5/22/26 at 1:16 P.M., CNA G said he/she was in another resident's room on 600 hall when the he/she heard a commotion. When he/she came out to check, CNA A and Resident #1 were yelling at each other. CNA told the resident, Shut the fuck up, then the resident responded, make me. CNA A then pushed the resident against the door. CNA G walked up to them and tried to get CNA An off the resident. The resident slid off and fell on the floor. CNA A had his/her hands on the resident's shoulders. Then CNA A got off and left the facility. CNA G said it happened too fast. He/She did not get a chance to talk to CNA A and call Code Green. CNA G was terminated after the incident. He/She was told by the Administrator that he/she did not put everything in his/her statement. He/She did not have similar incidents in the past and did not<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265823 | A. Building<br>B. Wing | 05/22/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Crestwood Health Care Center, LLC | 11400 Mehl Avenue<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | know how to respond at that moment. He/She should have called Code [NAME] and intervened immediately. During an interview on 5/22/26 at 2:45 P.M., the Director of Nursing (DON) and Administrator said they expected the staff to walk away from a situation when residents were having behaviors. She expected the staff to take a break, and ask for assistance, and report to the supervisor or DON when the situation escalated. When the DON called and notified CNA A that he/she was being suspended pending investigation, CNA A decided to resign. He/She admitted grabbing and pushing the resident. The Administrator said CNA G was terminated due to leaving out information during the investigation. Incident #3019870 |