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	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestwood Health Care Center	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. Based on interview and record review, the facility failed to ensure one resident (Resident #1) was free from physical abuse when Certified Nursing Assistant (CNA) A punched the resident in the head several times and had a physical altercation with the resident. The resident fought back, and the altercation was approximately 10 seconds long. The sample size was four. The census was 146. The Administrator was notified on 06/26/26 of the past non-compliance. The facility responded appropriately when the incident occurred. The facility sent CNA A home immediately after incident and began an investigation. The facility provided training and in-services for all staff regarding abuse and neglect, de-escalation techniques, tap-out procedure, and residents' rights on 06/18/26 through 06/24/26. The deficiency was corrected on 06/24/26. Review of the facility's Resident's Rights policy, revised 06/12/24, 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, dated 06/12/24, 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 record showed:~Diagnoses of Chronic Obstructive Pulmonary Disease (chronic long term lung disease the worsens overtime), schizoaffective disorder (mental Illness characterized by symptoms of delusions, disorganized thinking, and hallucinations), bipolar (a mental illness characterized by symptoms of grandiosity, delusions, hyper activity periods and periods of depression), and chronic congestive heart failure. Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 06/16/26, showed:~Cognition intact;-Required supervision and/or set up assistance with activities of daily living. Review of the resident's care plan, dated 06/16/26, showed:~Resident with cognitive limitations and/or illness. At risk for abuse, neglect, intimidation, and financial exploitation due to limited awareness of rights and fear of retaliation, leading to underreporting of concerns and delayed identification, of potential abuse. Date initiated 03/20/26; Revision 03/30/26;~Resident has the potential to be physically aggressive due to poor impulse control. He/she will be physically aggressive towards peers when he/she does not get what he/she wants. Date initiated 08/13/25; Revision 08/13/25. Review of the facility's investigation (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
	265823	A. Building B. Wing	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestwood Health Care Center	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	report, dated 06/23/26, showed:-Date and approximate time of incident: 06/23/26 at 10:00 P.M.;-Type of incident: Alleged Abuse;-Persons involved: Resident #1 and CNA A; -Date and time notified: 06/23/26 at 11:00 P.M.;-Investigative Narrative:The nurse was at the nurse's station assisting another resident when I looked over, and I saw what looked like a staff trying to break up an altercation. The nurse then went closer to the window and called a code green (behavior emergency) and went to assist staff. Nurse had got staff down to the end of the hall, and resident sitting in his/her wheelchair saying he/she wanted to go back down the hall and beat his/her ass. Resident was assisted into his/her room. Resident was assessed and had no raised, red, or bruised areas noted. Resident stated I was trying to get to the nurse's station to get to that b***h at the nurse's station so I could kick her a**. Neurological (neuro) checks (frequent assessment of mental status and neurological changes after head injury occurs for 72 hours) initiated. Physician, management team, and the authorities notified. Police department here and informed of incident. Resident placed on 1: 1 monitoring. Message left for the Public Administrator. Staff wrote a statement and was sent home immediately. Witness statements received. Both witnesses stated CNA A was trying to stop the resident from going to the nurses' station due to peer being out there with nurse. Resident had just had a verbal altercation with peer. Both witnesses also stated as soon as they saw them fighting, they went to separate and called a code green. When CNA A attempted to remove the resident's hand from the doorframe, the resident bit her in the back and broke the skin. Per CNA A, the resident also hit him/her in the head.-Conclusion/ Outcome of the investigation:Staff admitted she started hitting the resident back and hit him/her on the top of the head twice. CNA A further stated the resident stood up and pushed him/her against the wall. During an interview on 06/25/26 at 3:00 P.M., CNA A said he/she was returning from his/her break and had to slide him/herself between the unit doors that he/she barely opened because the resident was trying to leave the locked unit. CNA B was shouting don't let the resident out; so CNA A followed what was being shouted. The Resident yelled at CNA A not to close the door on his/her hand, as the resident tried to force his/her way out the doors. CNA A tried to move the resident's hand, and the resident then bit down on CNA A's lower back and wasn't letting go. CNA A started fighting the resident, and the resident was swinging and hitting him/her too. They were separated after a few seconds. CNA A reported what happened to the charge nurse on duty, and then CNA A was sent home. CNA A said he/she was defending him/herself and just reacted without thinking. Review of CNA A's employee file showed he/he had been a CNA for approximately 10 years. CNA A's date of hire was 06/01/26, and he/she was trained on abuse on 06/01/26. During an interview on 06/26/26 at 10:00 A.M., Registered Nurse (RN) D said he/she was on duty when the incident happened. He/She was told to call a code green and then proceeded to the unit. The resident and CNA A were separated. RN D brought the resident to his/her room and did a body assessment. The Resident was not hurt and continued to yell at staff, wanting to get to CNA A to kick his/her ass. The resident had some scratches and bruising on his/her head. RN D did not feel this was premeditated abuse, and it was a person defending themselves when a resident had latched down on the staff member's back, biting and not letting go. CNA A was sent home pending investigation, was not injured and had some minor abrasions. During an interview on 06/26/26 at 11:00 A.M., CNA B said CNA A was returning from break, and the resident was trying to exit the locked unit. CNA B yelled at CNA A to stop the resident from going through the doors because the resident was trying to force his/her way out of them. The resident had her/his hand on the door frame. CNA A tried to move the resident's hand, and this is when the resident said Don't smash my hand and bit CNA A on the back. CNA A began hitting the resident in the face. The resident was swinging back, and CNA B began yelling code green. CNA B and CNA C separated CNA A and the resident, the incident lasted about 10 seconds. The resident was fighting back and hitting CNA A with punches, and neither party obtained serious injuries. The nurse arrived immediately, and the resident went to his/her room to be assessed. CNA A was sent home after being assessed to have no injuries. During an interview on 06/26/26 at 11:30 A.M., CNA C said when CNA A was coming through the doors, he/she tried to (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 B. Wing	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestwood Health Care Center	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	remove the resident's hand from the doorframe. The resident said Don't smash my hand and bit CNA A. Then CNA A began hitting the resident, and a fight followed. CNA C and CNA B separated CNA A and the resident. CNA A was sent home, and the resident was placed on 1:1 monitoring. During an interview on 06/26/26 at 12:00 P.M., the resident said he/she is not fearful and glad the staff member is not coming back. The resident still wants to kick the staff member's ass. During an interview on 06/26/26 at 1:00 P.M., the Director of Nursing (DON) said the employee had been terminated for abuse. The DON confirmed the in-servicing completed, and felt this was a knee jerk reaction response by the CNA. The staff member was removed from building immediately pending investigation, and the resident was examined. Both the resident and the staff member had minor in injuries. 3053070