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	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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure food was appropriately labeled, dated, and/or sealed in an appropriate manner to prevent cross contamination and preserve food quality. The facility failed to ensure the dish machine and sanitizing sink were equipped with sufficient concentration of sanitizing solution to effectively clean and sanitize dishware. These deficient practices had the potential to affect all residents who ate at the facility. The census was 141.Review of the facility's Food Storage policy, undated, showed:-Frozen Meat/Poultry and Foods: Store items promptly at 0 degrees Fahrenheit (F). Foods shall be stored in their original containers if designed for freezing. Foods to be frozen shall be stored in airtight containers or wrapped in heavy-duty aluminum foil, plastic film, or special laminated papers. Label and date all food items;-Fresh Vegetables: Store at temperature of 41 degrees F or less;-Dry Storage: Any open products shall be placed in seamless plastic or glass containers with tight fitting lids or plastic bags. Open products may also be sealed by utilizing plastic film or tape;-Label and date all storage containers as follows: The received date should already be on it. Date when opened. Date when the item expires. 1. Observation of the facility's kitchen, on 4/26/26 at 8:15 A.M., showed:-The dry storage area contained an open, undated, and unsealed large bag of flour, an undated open bottle of caramel topping, an open and undated container of chili powder, a partially covered clear container containing oats, dated 3/3/26, and open bags of cornflakes, chips, yellow cake mix, muffin mix, and brown sugar sealed with plastic wrap and undated;-The prep area contained an open and undated container of powder sugar;-The shelf on the bottom of the stove contained an open and undated bottle of barbeque sauce;-The freezer contained open, undated, and unsealed boxes of cobbler crust, pizza dough, breaded cod, and cookie dough;-The refrigerator contained an undated and partially open container of mayonnaise, an open and undated container of relish, an open and undated container of lunch meat, and nine cartons of milk with a ?best used by' date of 4/25/26. Observation of the dry storage room on 4/29/26 at 7:40 A.M., showed an open, undated and unsealed bag of grits, and open bags of corn flakes and brown sugar, sealed with plastic wrap and undated. Observations of the kitchen on 4/29/26 at 8:50 A.M., showed the refrigerator contained two open and undated cartons of Med Pass (fortified nutritional supplement) and one open and undated carton of milk. The freezer contained open, undated and unsealed boxes of sausage, pork chops, and rolls, and an undated, torn plastic bag filled with carrots. During an interview, the Dietary Manager (DM) said when food is opened, it should be dated and the food should be sealed. Med Pass should not be stored in the kitchen refrigerator; it should be stored in the nurse's refrigerator. The freezer and refrigerator temps should be checked twice daily and documented on the log. 2. Review of the facility's Recording of Dish Machine Temperature policy, undated, showed:-Low temperature dish machine: the concentration of the sanitary solution during the rinse cycle is 50-100 parts per million (PPM, the unit of measurement used to ensure chemical sanitizers in the final rinse cycle are concentrated enough to kill microorganisms) with chlorine test strips;-When the chemical sanitizing dispenser is broken or not working correctly on the cold temp machine, appropriate amount of sanitizer, per manufacturer directions, can be manually added to the dish machine at each rinse cycle. Check for the correct (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	amount of sanitizer at each rinse cycle with appropriate litmus paper;-Record PPM on temperature machines three times daily. Review of the facility's Low Temperature Dishwasher Form, dated April 2026, showed:-Record temperature and PPM, where applicable once before each meal period;-Breakfast and lunch: One of 28 opportunities to document wash temperature and PPM were blank;-Dinner: Six of 27 opportunities to document wash temperature and PPM were blank. Observation and interview on 4/29/26 at 8:40 A.M., showed the DM placed a chlorine test paper strip in the water located in the dishwasher reservoir during the final rinse cycle. She said she was not getting a reading. The dishwasher is tested three times a day. During the interview, the DM asked Dietary Aide (DA) S if he/she obtained a reading on the test strip. DA S said he/she she did not know how to do the test. The DM attempted to complete the test a few more times and was unable to get a reading. She did not know why there was no reading because she could see the chemical coming out of the hose connected to the dishwasher. Review of the facility's Pot Sink Sanitation Record, dated April 2026, showed:-Columns to document time, PPM, and checked by for breakfast, lunch, and dinner;-Time not documented 19 of 26 opportunities;-PPM not documented 20 of 26 opportunities;-Checked by not documented 26 of 26 opportunities. Observation and interview on 4/29/26 at 8:30 A.M., showed the placed paper towels in the bottom of the third (sanitizing) sink of the 3-vat sink and filled the sink with water that came from a clear hose connected to a container with chemicals in it. The DM tore a piece of test strip off a roll of strips that had instructions to dip the strip in water for 10 to 15 seconds before reading. The DM dipped the test strip into the water and the tip of the strip turned green. The DM dipped the strip into the water several times and the strip did not change colors. The DM said maybe there was not enough sanitizer in the sink. During an interview on 4/29/26 at 11:35 A.M., the Dishwasher Repair Representative (dishwasher repairman from an outside company) said the dishwasher's squeeze tube was bad and required replacement. On the sanitizer sink, someone had placed the hose for the sanitizer in the wrong container. 3. During an interview on 4/29/26 at approximately 10:15 A.M. the Regional Dietary Manager said food should be dated when opened and sealed when stored. 4. During an interview on 5/1/26 at 1:00 P.M., the Administrator said she expected food to be stored in a safe and sanitary condition. Dishes should be appropriately sanitized. She expected staff to follow the facility's policies and procedures.

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. Based on interview and record review, the facility failed to ensure quarterly statements were distributed to residents and/or their responsible parties. This deficient practice affected all 101 residents whose funds were handled by the facility. The census was 141. Review of the facility's Resident Rights policy, last review date 9/21/25, showed the facility will keep a written account of all funds and provide resident or resident's designee or guardian a quarterly accounting of all financial transactions made on behalf of the resident. Review of the resident funds records provided by the facility, showed no documentation of quarterly statements. During an interview on 4/28/26 at 11:00 A.M., the Administrator said the facility managed 101 resident accounts. The Business Office Manager was responsible for sending out the quarterly statements, but did not send out the quarterly statements. The Administrator expected a written account of the residents' funds to be provided to the resident/resident representative quarterly.

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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 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 (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, 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 (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#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 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 (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	11400 Mehl Avenue Florissant, MO 63033

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, 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 (continued on next page)

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

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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], (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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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	265823	A. Building B. Wing	05/01/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hall, but he/she knew the resident was there during the night because the resident needed to be redirected during the night. When the nurse left the nurse's station at 6:15 A.M. to provide care for another resident, the resident was at the nurse's station. When LPN O returned to the nurse's station, he/she finished charting and left at the end of his/her shift. Around 2:00 P.M., he/she received a text message from the DON asking when the last time was, he/she saw the resident. The resident used the busy time of the day to leave. Some of the exit doors don't seal well and the alarms are unreliable. Staff could be desensitized to the alarms if the alarm sounded. During an interview on 4/30/26 at 8:15 A.M. LPN E said he/she rounded on the residents every two to three hours and the CNAs round every two hours. If a resident was not in their room, he/she would look for the resident. 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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	265823	A. Building B. Wing	05/01/2026

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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

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

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure 26 of 46 resident rooms, 17 of 46 bathrooms, and a shower room were adequately equipped with a functional call system that would allow residents to call for staff assistance. The census was 31. The census was141.Observations on 4/30/26 at 11:20 A.M., showed a test of call lights as follows:-On the 100 hall, call lights not functional in resident rooms 101, 105, 109, and 110, the 100 hall shower room, and the shared bathrooms of rooms 105/107 and 111/113;-On the 200 hall, call lights not functional in resident room [ROOM NUMBER] and the shared bathrooms of rooms 205/207 and 209/211;-On the 300 hall, call lights not functional in resident rooms 301, 302, 307, 309, 308, 311, 310, 312 and 313, and the shared bathrooms of rooms 302/304, 307/309, 311/313, 310/312;-On the 400 hall, call lights not functional in resident rooms 403, 404, 406 and 407, and the shared bathrooms of rooms 401/403 and 406/407;-On the 500 hall, call lights not functional in resident rooms 501, 510 and 513, and the bathrooms of resident rooms [ROOM NUMBER];-On the 600 hall, call lights not functional in resident rooms 601, 602, 605, 610, and 612, the lounge room of 613, the shared bathrooms of 601/603, 600/602, and 605/607, and the bathroom in room [ROOM NUMBER]. During an interview on 4/26/26 at 9:00 A.M. Certified Nurse Aide (CNA) B said he/she was aware the call light in room [ROOM NUMBER] was not working. It was reported to Maintenance but once they fix it, it just breaks again. During an interview on 4/30/26 at 11:20 A.M., the Maintenance Supervisor said he was not aware the call lights were not functioning. He expected nursing staff to notify Maintenance when something was not working so it could be addressed. During an interview on 5/1/26 at 1:00 P.M. the Administrator said if an item needed to be repaired, she expected staff to report it to Maintenance so they could address it. She expected the call lights to be functional throughout the facility.

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

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and record review, the facility failed to provide the Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN, -CMS-10055) or a denial letter at the initiation, reduction or termination of Medicare Part A benefits. The facility identified 11 residents, who discharged from Medicare covered Part A with benefits days remaining in the past six months. Three residents were sampled, and issues were found with all three residents (Resident #41, #12 and #35). The census was 141.Review of the facility's Advance Beneficiary Notices, dated 11/5/24, showed:--To ensure that the resident, or representative, has enough time to make a decision whether ornot to receive the services in question and assume financial responsibility, the notice shall beprovided at least two days before the end of a Medicare covered Part A stay or when all of PartB therapies are ending. The notices must not be provided while the resident/representative is under duress or in an emergency situation;--The notice shall be prepared with an original and at least two copies. The facilityshall retain the original and give a copy to the resident/representative;-The original notice shall be placed into the resident's financial file. The notice shall be retainedat least five years. Review of the list of Beneficiary Notice-Residents discharged Within the Last Six Months, completed by the facility, showed:-Resident #41 discharged from services on 12/23/25 and remained in the facility;-Resident #12 discharged from services on 12/21/25 and remained in the facility;-Resident #35 discharged from services on 2/16/26 and remained in the facility. During an interview on 4/29/26 at approximately 3:00 P.M. and on 4/30/26 at approximately 10:00 A.M., the surveyor requested the Beneficiary Notices for Resident #41, #12 and #35 from the Administrator. During an interview on 5/1/26 at approximately 1:00 P.M., the Administrator said she did not have the SNFABN for two out of the three residents. The third notice was not provided. She would expect the notices to be provided to the resident/resident representative when the residents were discharged from services and documented in the residents' medical record.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to maintain a homelike environment when the facility failed to ensure one toilet in a [NAME] and [NAME] bathroom (bathroom situated and directly accessible from two separate rooms) was functional (Resident #12). In addition, the facility failed to ensure one resident's bed had clean linen (Resident#114). The sample was 31. The census was 141.Review of the facility's Safe and Homelike Environment Policy, dated 6/5/2024, showed:-Housekeeping and maintenance services will be provided as necessary to maintain a sanitaryand comfortable environment;-The facility will provide and maintain bed and bath linens that are clean and in good condition;- Minimize odors by disposing of soiled linens promptly and reporting lingering odorsand bathrooms needing cleaning to housekeeping department. 1. Review of Resident #12's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/24/26, showed:-Moderate cognitive impairment;-Required supervision or touch assistance for personnel and toilet hygiene;-No behaviors;-Diagnoses included high blood pressure, anxiety, bipolar disorder (a mental health condition that causes extreme mood swings that include emotional highs (mania or hypomania) and lows (depression)) and schizophrenia (serious mental illness that affects how a person thinks, feels, and behaves). Observation on 4/26/26 at 8:30 A.M., showed the resident had a [NAME] and [NAME] bathroom. The toilet was clogged with brown substances. During an interview on 4/26/26 at 9:00 A.M., Certified Nurse Aide (CNA) B said the facility was aware the toilet was clogged, and when they unclogged it, the residents would clog it again. The CNA identified Resident #12 as who clogged the toilet and said they tried to keep the paper towels out. The CNA said he/she told the nurse when the toilet was clogged. He/She was not aware of any interventions put in place to try to prevent the resident from clogging the toilet. Observations on 4/26/26 at 8:30 A.M., 4/27/26 at 11:39 A.M. and 4/28/26 at 1:44 P.M., showed the toilet was clogged. During an interview on 4/29/26 at 9:30 A.M., the Administrator said she would expect the CNA and the housekeeping staff to notify maintenance when the toilet was clogged. She was aware the resident was known for clogging the toilet with paper towels. She would have expected staff to have made frequent checks of the bathroom and if the toilet was clogged, it should be reported immediately to maintenance. Observation on 4/29/26 at 11:30 A.M. showed the toilet was unclogged. During an interview on 4/29 at 1:30 P.M. the Maintenance Director said he had not been at the facility very long and was still learning the facility. He was not aware the toilet was clogged until the Administrator talked to him about it and he immediately took care of it. 2. Review of Resident #114's quarterly MDS, dated [DATE], showed:-Cognitively intact;-No behaviors or rejection of care;-Required supervision or touch assistance for personal and toilet hygiene;-Independent with dressing;-Always continent of bowels and bladder;-Diagnoses included: Alzheimer disease, Traumatic Brain Injury (TBI), depression, Schizophrenia and post-traumatic stress disorder (PTSD). Review of the resident's care plan, in use at the time of survey showed:-Problem: Risk for self-care deficit: bathing, dressing, feeding;-Goal: Resident will participate in self-care activities;-Interventions: Encourage resident to participate in planning day-to-day care. Evaluate functional abilities. Evaluate resident's ability to perform activities of daily living (ADLs, grooming, dressing, toileting and bathing). Maintain consistent schedule with daily routine. Provide assistance with ADLs as needed. Observation and interview on 4/26/26 at approximately 11:00 A.M., showed the resident lay in bed. There was a large dried yellow ring on the bottom sheet. The residents' clothes were dry. Observation on 4/29/26 at 1:32 P.M. and 4/30/26 at 1:00 P.M., showed the resident was not in the room. There was a large dried yellow ring on the bottom sheet. During an observation and interview on 4/30/26 at 1:10 P.M., the Social Services Assistant (SSA) said both the residents and the CNA's changed the bed linen. If the residents could not change the sheets, the CNAs should have done it. The resident was unable to change his/her bed (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	linen. She would not expect the resident's sheet to have a yellow ring on it. She would have expected the CNAs to make rounds and change the bed linens, as needed. During an interview on 4/30/26 at 8:15 A.M. Licensed Practical Nurse (LPN) E said the CNA's did rounds on residents every two hours. During their rounds they checked on the residents and provided ADL care. During an interview on 5/1/26 at 1:00 P.M., the Administrator said she was made aware of the residents' bed linen. The resident was given a shower, and the bed linens were changed. The CNAs were responsible for changing the bed linens on shower days and as needed. She would have expected staff to follow the facility's policies and procedures.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure accuracy of the Minimum Data Set (MDS), a federally required assessment instrument completed by facility staff. This deficiency affected two of 31 sampled residents (Resident #9 and Resident #28). The census was 141.Review of the MDS care assessment summary policy, revised 11/6/23, showed: -Purpose: To understand the changes presented by Centers for Medicare and Medicaid Services (CMS) 3.0, to define the intent of each section of the MDS 3.0 and to ensure that MDS sections are completed accurately and in a timely manner by the assigned responsible parties. -Procedure: -Section J is to be completed by nursing staff. This section addresses any condition that impacts the resident's quality of life and functional status; -Used to identify the number of health conditions that impact the resident's functional status and quality of life; -Areas in the section to assess are dyspena (difficulty breathing), prognosis, problem conditions and falls. -As the information from the MDS correlates with the Care Assessment Areas (CAAs), the staff that is responsible for that section should be the staff entering that information; -After completing the MDS 3.0, the facility will use the CAA to further assess the triggered areas of concern by helping the staff to look for casual or confounding factors, some of which may be reversible; -CAAs need to document the casual risk factors or unique risk factors for decline or lack of improvement; -MDSs must be kept current and up to date. 1.Review of Resident #9's physician order sheet (POS), showed: -An order, dated 12/23/25: Admit to hospice services. Review of the resident's significant change MDS, dated [DATE], showed: -Moderately cognitively impaired; -Diagnoses included stroke, heart failure, dysphagia (difficulty swallowing) and protein calorie malnutrition. -Section J: Prognosis: -Does the resident have a condition or chronic disease that may result in a life expectancy of less (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	than 6 months: No; -The significant change MDS did not correctly identify the enrollment into hospice services. Review of the care plan, in use during the survey did not address the enrollment of hospice services. 2. Review of Resident #28's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Diagnoses included high cholesterol, bipolar disorder (mental health condition characterized by mood swings from one extreme to another), schizophrenia (a serious mental health condition that affects how people think, feel and behave), and chronic obstructive pulmonary disease (COPD, incurable lung disease); -Diabetes Mellitus (DM, a condition that happens when your blood sugar is too high) was not included as an active diagnosis; -Hypoglycemic medication, including insulin (medication that helps lower blood sugar), was indicated as taken by the resident. Review of the resident's care plan in use at the time of survey, showed: -Problem: The resident was at risk for hyper/hypoglycemic episodes related to diagnosis of DM; -Goal: The resident will have no complications related to diabetes through the review date, -Interventions: DM medication as ordered by doctor. Monitor and document for side effects and effectiveness. Identify areas of noncompliance or other difficulties in resident's diabetic management. Review of the resident's electronic health records (EHR), showed no diagnosis of DM. The resident's electronic physician's orders sheet (ePOS), and Medication Administration Record (MAR), did not show an order for insulin. 3. During an interview on 5/1/26 at 9:26 A.M., the regional MDS coordinator said the facility used nurse assessment coordinators to complete resident questionnaires. The MDS is completed by reviewing the resident's medical record. The MDS should be accurate and reflect the current condition of the residents. 4. During an interview on 5/1/26 at 2:00 P.M., the Administrator and Director of Nursing (DON) said they expected the MDS to be accurate and reflect the care needs of the residents. Hospice should be accurate on the MDS as well as the medications that are administered. Ozempic is not an insulin class of medication.

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview and record review, the facility failed to update a resident's comprehensive care plan following admission into hospice services (Resident #9). The sample size was 31. The census was 141.Review of the facility's Comprehensive Care plan policy, reviewed 10/31/24, showed:-Purpose: To develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and time frames to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the resident's comprehensive assessment;-Person centered care: To focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives;-Policy:-The care planning process will include an assessment of the resident's strengths and needs, and will incorporate the resident's personal and cultural preferences in developing goals of care. Services provided or arranged by the facility as outlined by the comprehensive care plan, shall be competent;-The comprehensive care plan will be developed within seven days after completion of the comprehensive Minimum Data Set ((MDS) a federally mandated assessment instrument completed by facility staff) assessment;-The comprehensive care plan will describe, at a minimum:--The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being;--The comprehensive care plan will be reviewed and revised by the team after each comprehensive and quarterly MDS assessment. Review of Resident #9's medical record, showed:-admitted to hospice services on 12/23/25;-Diagnoses included stroke, failure to thrive, protein calorie malnutrition, and difficulty swallowing. Review of the care plan, in use during the survey, did not address hospice admission or hospice care plan and the facility responsibility of care needs. During an interview on 5/1/26 at 9:26 A.M., the Regional MDS Coordinator said the care plan should have reflected the accuracy of the resident conditions. Hospice services should have been addressed on the care plan. The care plan should have addressed what services the hospice provider would address and what services the facility would provide. The care plan was used to direct resident care and should have been updated as the resident's needs changed. During an interview on 5/1/26 at 2:00 P.M., the Administrator and Director of Nursing (DON) said the care plans should be accurate and updated to reflect the needs of the resident. The care plan was individualized to reflect care services by outside providers, including hospice services. As the resident's needs changed the care plan should be updated to reflect the changes.

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	11400 Mehl Avenue Florissant, MO 63033

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure care was provided in accordance with professional standards of practice by not following physician's orders when staff administered the wrong medication to one resident (resident #92). The sample size was 31. The census was 141. Review of the facility's Transcription of Orders/Following Physician's Orders policy, revised 5/18/24, showed:-The purpose of this policy is to outline procedures in accurately transcribing physician's orders and to ensure that all physicians' orders are followed;-To ensure a process is in place to monitor nurses in accurately transcribing and following physician's orders;-Clarification of Physician's Orders will be obtained if the order is either unclear or the nurse is uncomfortable in implementation of the Physician's Orders;-The RCC (Resident Care Coordinator)/Unit Manager/Designated Nurse will review all electronic MARs/TARs (Medication Administration Record/Treatment Administration Record) and compare all medications to the medications available for each resident in the facility weekly to ensure availability;-The Physician is expected to sign all of their orders electronically in the Electronic Health Record. Review of the facility's Medication Administration policy, revised 6/26/24, showed:-Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with the professional standards of practice, in a manner to prevent contamination or infection;-It is the policy of this facility to ensure the safe and effective administration of all medications by utilizing best practice guidelines;-Ensure the six rights of medication administration are followed;--Right resident;--Right drug;--Right dosage;--Right route;--Right time;--Right documentation;-Review MAR to identify medication to be administered;-Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time. Review of Resident #92's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/6/26, showed:-admitted on [DATE];-Cognitively intact;-Diagnoses included anxiety, depression, and Schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions);-Medications included antipsychotic, antianxiety, and antidepressant. Review of the resident's MAR, dated 4/1/26 through 4/30/26, showed:-On 4/7/26, an order of Hydroxyzine HCl (antianxiety) oral tablet 50 milligrams (mg), to give 50 mg by mouth three times a day for paranoia;-The medication was discontinued on 4/24/26;-The medication was administered from the morning of 4/7/26 through 4/23/26 at bedtime;-On 4/24/26, there was an order of the same medication, dose, and frequency for generalized anxiety disorder;-The medication was started on 4/24/26 at noon;-On 4/24/26, an order for Hydralazine HCl oral tablet 50 mg, to give one tablet by mouth two times a day for HTN (hypertension, high blood pressure);-The medication was started on the morning of 4/25/26. Review of the resident's progress note, dated 4/24/26 at 10:15 A.M., showed Licensed Practical Nurse (LPN) M documented he/she received a report by Certified Nurse Assistant (CNA) about a discrepancy with medication. The resident had an order for Hydroxyzine 50 mg by mouth three times a day for paranoia. Hydralazine was dispensed by pharmacy. The resident was assessed, and vital signs were checked. The LPN noted no adverse reactions. The medical physician ordered Hydralazine for high blood pressure. The psychiatric Nurse Practitioner (PNP) ordered to continue to monitor mood and behaviors. During an interview on 4/26/26 at 11:25 A.M., the resident said he/she was told the day before by staff that there was a medication error. He/She was upset and asked for all the medications ordered by his physician. He/She did not have any reactions and did not feel anything unusual. During an interview on 4/29/26 at 9:49 A.M., LPN M said they obtained the residents' orders from the discharge summary report. They verified the orders with the physicians via telephone. The PNP came every week and reviewed the orders. The orders were entered into Point Click Care (PCC, the facility's electronic health records system), then the pharmacy received the (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	orders. Resident #92 received Hydralazine 50 mg three times a day, instead of Hydroxyzine 50 mg three times a day. The pharmacy dispensed the wrong cards. When the physician was notified of the error, an order was to continue Hydralazine 50 mg two times a day since the resident had elevated blood pressure readings. LPN M said the medication cards should have been checked against the orders to administer the correct medication. During an interview on 4/29/26 at 10:10 A.M., the pharmacy technician (PT) said the residents' orders were entered into PCC by the facility to transmit the orders electronically. According to the pharmacy records, Resident #92's orders were Hydralazine 50 mg by mouth two times a day, and Hydroxyzine 50 mg by mouth three times a day. The resident's Hydralazine 50 mg was ordered and dispensed on 4/6/26 three times a day and was changed to two times a day on 4/24/26. An order of Hydroxyzine 50 mg three times a day was added on 4/24/26. Observation and interview on 4/29/26 at 10:35 A.M., showed the 500 hall medication cart had Hydralazine 50 mg cards with a fill date of 4/7/26, to be given by mouth three times a day. The morning dose had nine tablets left, while the evening dose had 10 tablets left. There were three more unopened cards (90 tablets), with fill date of 4/24/25, and another two more cards (60 tablets), with fill date of 4/24/26. There were three cards of Hydroxyzine 50 mg, one for each morning, noon, and evening doses, with fill date of 4/24/26. Certified Medication Technician (CMT) G said the resident was not supposed to take Hydralazine 50 mg tablet. The resident's order was for Hydroxyzine 50 mg tablet three times a day. The pharmacy sent Hydralazine 50 mg. The CMT said, it threw us all off, until another CMT caught the error. The resident had been taking Hydralazine three times a day, instead of Hydroxyzine, since admission until 4/24/26. He/She said they should have checked the orders and compared the MAR with the medication cards before administering the medications to the residents. CMT G said the resident was a little upset when they notified him/her about the error. No unusual behaviors were observed. During an interview on 4/30/26 at 1:00 P.M., the PNP said she was notified by the facility of the resident's medication error the day it was found out. She advised the staff to observe the resident's behaviors and to notify the medical physician. The resident could have potentially destabilized and would have increased behaviors. No report was received from the facility of the resident having increased behaviors. She expected the staff to use the rights of medication administration and follow the physician's orders. During an interview on 4/30/26 at 1:55 P.M. the Director of Nursing (DON) said she expected the staff to follow the resident's physician orders and follow the medication administration policy.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. Based on observation, interview and record review, the facility failed to ensure residents who needed assistance with nail care, received timely nail care services. The delay in services resulted in long, jagged and unkempt toenails (Resident #107 and Resident #12). The sample was 31. The census was 141.Review of the nail care policy, revised 6/26/24, showed:-Purpose: To provide guidelines for the provision of care to a resident's nails for good grooming and health;-Policy: -Assessments of nails will be conducted on admission and readmission to determine the nail condition, needs, and preferences for nail care: -Report unusual or abnormal conditions of the nails to the physician and the responsible party (curling, color changes, separation from the nail bed, redness, bleeding, pain, odor, and infection); -Obtain history and preferences regarding podiatry; -Identify conditions that increase risk for foot or nail problems, such as diabetes, vascular disease, heart failure, renal disease or stroke; -Routine cleaning and inspection of nails will be provided during daily care on an ongoing basis; -Routine nail care, to include trimming and filing, will be provided on a regular schedule (such as weekly). Nail care will be provided between scheduled occasions as the need arises; -The resident's plan of care will identify: -The frequency of nail care to be provided; -The type of nail care to be provided; -The person responsible for providing nail care; -Principles of nail care: -Nails should be kept smooth to avoid skin injury; -Only licensed nurses shall trim or file nails of residents with diabetes; -If a resident has diabetes mellitus, renal failure or vascular disease, trimming should be preformed by a physician or practitioner; -Residents without complicating disease processes, may have the nails clipped by staff who have received education and training to provide the service within professional standards of practice and as per facility policy; -Each resident will have his/her own nail care equipment. Equipment will not be shared between residents. Clean equipment after each use and before storing. 1. Review of Resident #107's medical record, showed:-re-admitted : 11/4/24;-Diagnoses included irregular heat beat, anxiety, heart disease, delusional disorder (persistent, fixed false beliefs (delusions) lasting at least one month, kidney disease and venous insufficiency. Review of the electronic physician order sheet (ePOS), showed:-An order dated 11/4/24: May see the Podiatrist. Review of the quarterly Minimum Data Set (MDS) a federally required assessment instrument, completed by facility staff, dated 2/3/26, showed:-Moderate cognitive impairment;-Staff provide supervision and touch assistance for bathing;-Staff provide moderate assistance with applying footwear. Review of the care plan, in use during the survey, did not address the resident's nail care needs. Review of the podiatry visit note, dated 2/4/26, showed:-History of present illness: At risk foot care;-Advanced trophic changes: -Nail thickening on both feet; -Nails are yellow, discolored, crumbly. Multiple nails are long and curved;-Plan: Nails trimmed with a nail clipper. A file was also used;-Follow up: Exam in two to three months. Observations on 4/26/26 at 8:10 A.M., and at 11:43 A.M., showed the resident sat up in bed. Both of the resident's feet were exposed and had very dry and scaley skin. Multiple toenails were long, scaley and curved. During interviews on 4/27/26 at 9:09 A.M. and 2:30 P.M., the resident said he/she had seen the foot doctor previously to trim his/her toenails. He/She could not recall the last time the Podiatrist examined his/her toenails. He/She had dry feet and staff do not put lotion on his/her feet. He/She wanted to see the Podiatrist soon. Staff did not provide nail trimming or filing. Observation on 4/29/26 at 7:18 A.M., showed the resident sitting up in bed, with both feet exposed. Both feet were dry and flakey with long nails. 2. Review of Resident #12's ePOS, showed:-An order, dated: 11/19/24, may see podiatry. Review of the medical record, showed:-re-admitted : 12/15/25;-Diagnoses included diabetes, high blood pressure, schizophrenia (delusions or paranoid thoughts), heart attack, and dementia. Review of the care plan, revised 12/29/25, showed:-Problem: The resident is resistive to care due to delusional thoughts;-Goal: The resident will cooperate with care;-Interventions: Allow the resident to make decisions, educate the resident regarding refusal of care.-Problem: The resident has diabetes; -Goal: The resident will have no complications; -Interventions: Administer medications as (continued on next page)

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

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ordered, and monitor for hypoglycemia (low blood sugar);-The care plan did not address diabetic foot care. Review of the skin check assessment, dated 4/27/26, showed:-No skin issues;-Foot evaluation completed;-No additional notes documented regarding foot care. Observation and interview on 4/29/26 at 8:09 A.M., showed the resident in bed with his/her feet exposed. The toenails of both feet were long, very thick and the nails were curled under some of the toes. The resident said his/her feet hurt so much. Staff had not provided nail trimming, and he/she had not seen the podiatrist since admission. During an interview on 4/29/26 at 8:10 A.M., Certified Nurse Aide (CNA) D said if a resident had long toe nails, staff should notify the Social Worker. The resident needed some assistance with daily care. He/She did not trim his/her own toenails. The resident frequently refused care. CNA D had not reported the long nails to the Social Worker and assumed the nurse was aware. 3. During an interview on 5/1/26 at 12:30 P.M., the Director of Social Services said nursing staff were responsible for notifying her if the resident needed to be seen by Podiatry. She will add the residents to the Podiatry list. She expected the nurses to perform nail filing between Podiatry appointments. 4. During an interview on 5/1/26 at 1:00 P.M., the Administrator and Director of Nursing said they expected the aides to report long nails to the charge nurse. The charge nurse should provide an assessment and file or trim the nails. Residents nails should be assessed weekly during the skin assessment. Residents with long nails should be scheduled with the Podiatrist. If a resident refused nail care, it should be documented and noted in the care plan. Residents with diabetes should be assessed by podiatry.

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F 0729 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining. Based on interview and record review, the facility failed to ensure the Nurse Aide (NA) registry verifications were checked before allowing four employees to work and provide care to residents (Employees AAA, CCC, DDD, and EEE). The census was 141.Review of the facility's Background Investigations policy, revised on 12/27/24, showed:-Job reference checks, drug screenings, licensure verifications and criminal conviction record checks are conducted on all personnel making application for employment with this company;-The Human Resource department will conduct all applicable background investigation(s) on each individual making applications for employment with this company and on any current employee if such background investigation is appropriate for position for which the individual has applied;-For all applicants applying for a position as a certified nurse aide, the human resources department will contact the nurse aide registry of the state in which the individual is certified and/or previously employed to verify that the applicant's certification is in good standing;-The facility will not employ individuals who:--Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;--Have had a finding entered into the state nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents, or misappropriation of resident property;--Have a disciplinary action in effect against his or her professional license in a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of resident, or misappropriation or resident property;--All inquiries regarding background investigations should be directed to the Director of Human Resources or Administrator. 1. Review of Employee AAA's employee file, showed:-Date of hire (DOH) - 6/24/25;-No documentation of NA registry verification was checked. 2. Review of Employee CCC's employee file, showed:-DOH - 3/13/26;-No documentation of NA registry verification was checked. 3. Review of Employee DDD's employee file, showed:-DOH - 4/3/26;-No documentation of NA registry verification was checked. 4. Review of Employee EEE's employee file, showed:-DOH - 1/12/26;-No documentation of NA registry verification was checked. 5. During an interview on 5/1/26 at 2:21 P.M., Human Resources (HR) personnel said she only checked nursing staff for the NA registry verification. She was not aware that non-nursing staff were supposed to be checked for NA registry. HR personnel said all four sampled employees' NA registry was checked during the survey when she was made aware by the DON. 6. During an interview on 5/1/26 at 1:00 P.M., the Administrator and the Director of Nurses (DON) said all the employees' onboarding requirements should be completed upon hire. HR was responsible for making sure the NA registry verifications were checked for newly hired employees.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure its medication error rate did not exceed five percent or greater. Five errors were observed out of 25 opportunities, with a 20 percent error rate (Residents #5, #16, #23, and #102). The sample was 38. The census was 141.Review of the facility's Medication Administration policy, revised 6/26/24, showed:-Purpose: Medications are administered by licensed staff and as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. It is the policy of the facility to ensure the safe and effective administration of all medications by utilizing practice guidelines;-Policy:-Ensure that the six rights of medication administration are followed: right resident, right drug, right dosage, right route, right time, and right documentation;-Administer medications within 60 minutes prior to or after scheduled time unless otherwise ordered by the physician. Review of the facility's Administration of Insulin policy, reviewed 5/14/24, showed:-Purpose: To provide timely administration of insulin to meet the needs of each resident and to prevent adverse effects. The facility uses insulin pens to improve the accuracy of insulin dosing, provide increased resident comfort;-Policy: -Administration of insulin:--All insulin will be administered in accordance with physician orders; -Insulin Pens:--Insulin pens are to be primed prior to each use to avoid collection of air in the insulin reservoir. 1. Review of Resident #5's medical record, showed diagnoses included diabetes. Review of the resident's electronic physician order sheet (ePOS), showed an order, dated 1/1/26, for Humalog (fast acting insulin) [NAME], three times a day, inject per sliding scale:-100 to 150: Inject 2 units;-151 to 200: Inject 4 units;-201 to 250: Inject 6 units;-251 to 300: Inject 8 units;-301 to 350: Inject 9 units;-Above 400: Inject 12 units and call the physician. Observation and interview on 4/29/26 at 7:55 A.M., showed Licensed Practical Nurse (LPN) E obtained the resident's fasting blood glucose (FBG, a measurement of sugar in the blood). Per the glucometer, the result was 211. LPN E said per physician order, the resident would receive 6 units of Humalog. LPN E applied gloves, obtained the resident's Humalog pen, and dialed 2 units and pressed the plunger. LPN E then removed the gloves, sanitized his/her hands, applied clean gloves, then applied the insulin needle to the end of the insulin pen. LPN E dialed 6 units on the insulin pen and administered the insulin to the resident. LPN E said he/she did not prime the insulin needle prior to administration of the insulin. He/She did not know he/she needed to prime the needle prior to administration. 2. Review of Resident #16's medical record, showed diagnoses included chronic pain, stroke, high blood pressure, dysphagia (difficulty swallowing), and paralysis of the right side. Review of the resident's ePOS, showed an order, dated 6/13/25, for gabapentin (used to treat nerve pain) 100 milligrams (mg), take one capsule three times a day for pain. Observation and interview on 4/29/26 at 12:20 P.M., showed Certified Medication Technician (CMT) F obtained the resident's gabapentin medication card and reviewed the physician order. CMT F dispensed one capsule into his/her bare hand. CMT F opened the capsule with bare hands and emptied the medication into a plastic cup. Multiple medication beads from the opened capsule touched CMT F's fingertips while being poured into the cup. CMT F filled the cup with fluid, stirred the fluid, and assisted the resident to drink the mixture. CMT F said he/she had forgotten to apply gloves before opening the medication capsule and a few medication beads touched his/her fingers. Gloves should be worn when handling medications. 3. Review of Resident #23's medical record, showed diagnoses included tremors, seizures, and schizophrenia (a mental health disorder that affects how a person thinks, feels and behaves). Review of the resident's ePOS and Medication Administration Record (MAR) for April 2026, showed, an order, dated 2/20/25 for Austedo (used to treat uncontrolled tremors) 12 mg tablet and 6 mg tablet, take one tablet of 12 mg and 6 mg twice daily. Scheduled for 7:00 A.M. and 3:00 P.M. Observation and interview on 4/29/26 at 10:28 A.M., showed CMT G obtained the resident's 12 mg and 6 mg Austedo medication cards. CMT G dispensed one tablet of each medication into a plastic medication cup and administered the medication to the (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident. CMT G said the medication was ordered to be administered at 7:00 A.M., for the morning dose. He/She had been late to begin the morning medication pass. Medications should be administered within an hour of the ordered time. 4. Review of Resident #102's medical record, showed diagnoses included paranoid personality disorder, bipolar disorder, (a mood disorder resulting in emotional highs and lows), and substance abuse history. Review of the resident's ePOS and MAR for April 2026, showed an order, dated 4/22/25, for olanzapine (used to treat psychosis and bipolar disorders) 15 mg disintegrating tablet, take one at bedtime daily. Scheduled for 7:00 P.M. Observation and interview on 4/28/26 at 5:00 P.M., showed CMT H obtained the resident's olanzapine 15 mg medication card. CMT H reviewed the physician order, dispensed one tablet into a small plastic cup, and administered the medication to the resident. CMT H ensured the medications were swallowed and documented the administration into the resident's medical record. CMT H said the medication was ordered to be taken at 7:00 P.M. He/She started the evening medication pass early to complete other tasks. Medications should not be administered more than an hour before the ordered administration time. 5. During an interview on 5/1/26 at 2:00 P.M., the Director of Nursing (DON) said she expected staff to administer medications as ordered. Medications can be administered an hour before or an hour after the physician-ordered administration time. Staff should not use ungloved bare hands to touch or handle medications. Insulin pen needles should be primed prior to administration of the insulin.

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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to post nurse staffing information that included the actual hours worked by both licensed and unlicensed nursing staff directly responsible for resident care per shift, on a daily basis. The census was 141.Review of the facility's Nurse Staffing Posting Information policy, revised on 6/26/24, showed:-Purpose: It is the policy of this facility to make nurse staffing information readily available in a readable format to residents and visitors at any given time;-Policy:-The Nurse Staffing Sheet will be posted on a daily basis and will contain the following information:--Facility name;--The current date;--Facility's current resident census;--The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:---Registered Nurses (RNs);---Licensed Practical Nurses (LPNs)/Licensed Vocational Nurses (LVNs);---Certified Nurse Aides (CNAs);--The facility will post the Nurse Staffing Sheet at the beginning of each shift;--The information posted will be:---Presented in a clear and readable format;---In a prominent place readily accessible to residents and visitors;--A copy of the schedule will be available to all supervisors to ensure the information posted is up-to-date and current;---The information shall reflect staff absences on that shift due to call-outs and illness;---After the start of each shift, actual hours will be updated to reflect such;---Staffing shall include all nursing staff who are paid by the facility (including contract staff);---Any staff not paid for by the facility, such as hospice staff or individuals hired by families, shall not be included;--Nursing schedules and posting information will be maintained in the Human Resources Department for review for a minimum of 18 months or as required by State law, whichever is greater;--The facility will, upon oral or written request, make the nurse staffing data available to the public for review at a cost not to exceed the community standard. Observation on 4/26/26 at approximately 8:05 A.M., showed no nurse staffing information posted at the facility's lobby or at the reception area. Observation on 4/30/26 at 8:58 A.M., showed the facility's Daily Staffing Hours sheet, dated 4/27/26, pinned in a cork board behind the reception area. During an interview, Receptionist C said he/she did not pay attention to the sheet. The Staffing Coordinator posted the staffing sheets. During an interview on 4/30/26 at 10:01 A.M., the Staffing Coordinator said she took the position a few months ago and was just made aware recently that the nurse staffing information had to be posted daily. She was too busy and forgot to post it daily. During an interview on 5/1/26 at 3:35 P.M., the Administrator said the nurse staffing information should be posted daily. The posting should be placed in public view. The board behind the reception area is not highly visible to the public or residents.