STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265823	A. BUILDING _____ B. WING _____	08/26/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CRESTWOOD HEALTH CARE CENTER, LLC	11400 MEHL AVENUE FLORISSANT, MO 63033

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**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 each resident receives adequate supervision to prevent accidents by not following their protocols for resident monitoring on the 600 hall locked unit for one resident (Resident #1) who had verbalized a desire to leave the facility. Staff failed to ensure Resident #1 returned inside after the 9:00 P.M. smoke break on [DATE]. In addition, staff failed to monitor the residents per facility protocol. The certified nursing assistants (CNAs) and licensed nurses for the 3:00 P.M. to 11:00 P.M. and 11:00 P.M. to 7:00 A.M. shifts incorrectly documented the resident was in the facility during hourly resident checks after the 9:00 P.M. smoke break. The facility failed to identify the resident as missing until approximately 6:30 A.M. on [DATE], when the certified medication technician (CMT) could not locate the resident for morning medications. The resident climbed an approximate 6 foot fence to get out of the facility smoking area. He/she walked approximately half a mile away to a gas station, where police were called and the resident was sent to the hospital. The resident was located by the facility at the hospital on [DATE] at approximately 8:30 A.M. The census on the locked unit was 21, and approximately 13 of the 21 residents smoke. The census was 140. The administrator was notified on [DATE] at 3:53 P.M. of an Immediate Jeopardy (IJ) which began on [DATE]. The IJ was removed on [DATE], as confirmed by surveyor onsite verification. Review of the facility's Monitoring of Residents on Visual Face Checks policy, dated [DATE], showed: -Affected Personnel: All facility staff; -Purpose: To ensure a system is in place for residents who require increased monitoring for behavioral/psychiatric and medical issues. Monitoring staff on units with residents who require more intensive monitoring; -Procedure: Residents who require more monitoring due to medical, behavioral/psychiatric symptoms will be monitored on visual face checks; -Residents may require more intensive monitoring based on their medical and behavioral/psychiatric needs. The resident will be assessed to determine the reason for the intensive monitoring, the length of time for intensive monitoring and the frequency of the intensive monitoring. This will be completed by administrative staff; -Residents who are showing poor impulse control including verbal/physical aggression, elopement ideations, suicidal/homicidal ideations, decompensation mentally and medically may also be placed on one to one (1:1, within eyesight of staff at all times) monitoring at the discretion of the Administrative staff; -Residents may require based on behavior/medical issues a less intensive monitoring which would require staff to visually check the resident more often than every 15 minutes; -All residents on each unit will be monitored by visual checks at least within 30 minutes; -If a unit has 12 or more residents that require less intensive monitoring of more than 15 minutes then staffing for the unit will include an additional staff member at all times; -Visual face checks will be documented on the 1:1 monitoring form and reviewed daily by the administrator/designee and or the Director of Nursing (DON)/designee including the 15 and 5 minute face checks and the 1:1 monitoring. Review of Resident #1's Preadmission Screening and Resident Review (PASRR, a tool used to screen residents for evidence of serious mental illness and/or intellectual disabilities, developmental disabilities, or related conditions to determine appropriateness of placement in a nursing facility and to calculate a resident's service needs) level 2 evaluation, dated [DATE], showed: -Records indicate [DIAGNOSES REDACTED]. Records indicate mild mental [MEDICAL CONDITION] and borderline intellectual functioning. [MEDICAL CONDITION] at age 14 with resulting poor impulse control and cognitive issues, per referral documentation. Left eye [MEDICAL CONDITION] due to gunshot wound (pellet gun), history of inhalant abuse. Records indicate history of auditory hallucinations on regular basis, insight and judgement impaired, cognitive issues, confused; -Overt behaviors: Frequent/continuous yelling, pacing, impatient/demanding, wandering, physically threatening, suspicious of others; -Cognitive skills/adaptive functioning: -Makes good decisions: No; -Stays on task: No; -Follows complex directions: No. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated [DATE], showed: -admitted [DATE]; -No mood concerns identified; -Exhibited hallucinations, delusions; -Physical behaviors and rejection of care exhibited ,[DATE] days; -Wandering behavior not exhibited; -No mobility devices required; -[DIAGNOSES REDACTED]. Review of the resident's 5-day MDS, dated [DATE], showed: -Readmitted [DATE]; -Moderate cognitive impairment; -Ambulates independently; -[MEDICAL CONDITION] not exhibited; -Behavioral symptoms not exhibited; -Wandering behavior not exhibited; -[DIAGNOSES REDACTED]. Review of the resident's facility medical record, showed: -A smoking assessment, dated [DATE], showed: -Is a smoker; -Does the resident have a history of poor judgement regarding safety of themselves or others? No; -Is the resident able to move freely without assistance? Yes; -Does the resident show good insight and judgement? Yes; -Is the resident compliant with the facility rules? Yes; -Is the resident an elopement risk? No; -Is the resident currently allowed to go off the unit unsupervised? No; -Is the resident safe to smoke unsupervised? Yes; -An order, dated [DATE], for [MEDICATION NAME] (anti-anxiety medication) 2 milligrams (mg) by mouth four times daily as needed (PRN) for 14 days; -A certified nurse aide (CNA) care plan, undated, showed: -Elopement: No; -Face checks every 15 minutes; -Behavioral: High. Physically aggressive, verbally aggressive, non-compliant, combative. Review of the resident's care plan, printed [DATE], and in use at the time of the abbreviated survey showed: -Problem, onset date of [DATE]: Resident can be verbally inappropriate, often with references of delusions/hallucinations. He/she can be very intrusive with disregard for other's personal space, has periods of impulsiveness/restlessness, and can be physically/verbally aggressive with staff/peers; -Approaches include: -Monitor resident for signs/symptoms of mood/behavior disturbances of persistence. Document and report observations to the physician; -Provide resident with other outlets for frustration and anxiety; -During period of anxiety/agitation, reduce environmental stimulation to a minimum or remove resident from the source of agitation; -Administer PRN medications as ordered; -Update [DATE]: Noted physical aggression toward staff. PRN given and resident placed on 1:1; -Update [DATE]: Noted agitation with staff, threatening behavior, yelling, unable to control. He/she ran across the hall and tried to attack peer, who closed the door on him/her and resident hit the door instead. He/she ran back to his/her room and proceeded to punch his/her roommate, hitting them in the nose. Resident given PRN and was sent to hospital for evaluation; -Update [DATE]: Resident was outside smoking when he/she and a peer started displaying increased agitation, leading to physical aggression. PRN medication given; -Problem, onset date of [DATE]: Resident has impaired decision making with limited judgement/insight related to his/her [DIAGNOSES REDACTED]. He/she has periods of delusions/hallucinations that may further impact his/her cognitive skills; -Approaches include: -Give verbal cueing/reminders as needed with daily tasks and for protective oversight; -Monitor for any changes in his/her mood/behavior pattern, refer as needed for psychiatric evaluation; -Assess for changes in his/her cognitive pattern that may further impact his/her communication abilities; -Assess for changes with his/her baseline level of functioning and refer to evaluation as needed. Review of the facility's self-report to the Department of Health and Senior Services, received on [DATE], showed Resident #1 was reported as missing from the facility on [DATE] at 6:50 A.M. Staff contacted police and searched for the resident at local businesses. A gas station attendant said a person matching the resident's

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) description was in the gas station around 1:00 A.M. The police were notified and the resident was taken to a local hospital for evaluation after making delusional statements about bugs crawling all over him/her. Review of Google Maps, showed: -Distance from facility to the gas station: 0.5 miles; -Walking time: 10 minutes. Observation on [DATE] at approximately 9:15 A.M., showed the facility located on a hilly two lane road with a speed limit of 25 miles per hour (mph). A partial sidewalk on the same side of the facility ended and resumed, and the resident would have to pass several side streets and driveways. The resident would have to turn left at the end of the two lane road, onto a four lane road with a speed limit of 45 mph and a sidewalk leading to the gas station. The gas station located approximately 0.1 miles from a six lane interstate. During an interview on [DATE] at 9:30 A.M., the administrator said Resident #1's room was on the 600 hall, a locked unit. Staff should check the residents every hour. When residents receive smoke breaks on the unit, one staff should go outside to the courtyard, while the other staff lets residents outside. One staff remains outside with residents during the smoke break, while the other staff remains inside to monitor residents who do not smoke. Once the smoke break is over, the staff outside with the residents should count them as they return to the building. On [DATE], CNA A was assigned to the 600 hall for the 3:00 P.M. to 11:00 P.M. shift. Upon reviewing the facility's surveillance footage, the administrator saw CNA A let the residents, including Resident #1, go outside for the evening smoke break around 9:00 P.M. Maintenance Assistant (MA) L remained inside with non-smoking residents. When CNA A let the residents back inside the building, Resident #1 did not return. Staff should have counted the residents as they came back inside. CNA A sat in a chair right outside of Resident #1's room and marked the hourly monitoring checks as having been completed for the resident; however, Resident #1 was not in his/her room. When the CMT arrived to pass medication on [DATE] at 6:30 A.M., he/she could not locate the resident and called a Code White, notifying all staff that a resident was missing. Staff searched the area nearby for the resident, and located a gas station attendant who reportedly saw the resident just before 1:00 A.M. According to the gas station attendant, Resident #1 exhibited irrational behavior, so the police were notified and the resident was taken to a local hospital. Staff contacted the hospital and verified Resident #1 was there and had no injuries. Resident #1 returned to the facility on [DATE] between 11:00 A.M. and 12:00 P.M. When the administrator interviewed the resident about what happened, he/she said he/she thought someone would see him/her outside and would let him/her back in. He/she waited in the courtyard for hours, then hopped the fence and walked to the gas station where he/she died . Resident #1 was not an elopement risk prior to the incident on [DATE], but now he/she is. The administrator said Resident #1 was not the cause of the problem, and the incident was a people failure. CNA A should have checked on the residents hourly, and should not have lied on the hourly monitoring log. Ultimately, the charge nurse is responsible because he/she should have checked the residents as well. Review of the 1 Hour CNA Intensive Monitoring Checks for the 600 hall, dated [DATE], showed: -Place a check in the box signifying that the resident was seen face to face. If the resident is not seen on the unit, use key to signify location; -Checkmarks and slashes in the boxes next to Resident #1's name hourly, from 7:00 A.M. on [DATE] to 5:00 A.M. on [DATE]; -By signing below, I confirm that I have visually checked all residents on my assigned unit and all residents are accounted for; -CNA A signed for the 3:00 P.M. to 11:00 P.M. shift; -CNA K signed for the 11:00 P.M. to 7:00 A.M. shift. Review of the 1 Hour Licensed Nurse Intensive Monitoring Checks for the 600 hall, dated [DATE], showed: -Place a check in the box signifying that the resident was seen face to face. If the resident is not seen on the unit, use key to signify location; -Slashes and dashes in the boxes next to Resident #1's name hourly, from 7:30 A.M. on [DATE] to 6:30 A.M. on [DATE]; -By signing below, I confirm that I have visually checked all residents on my assigned unit and all residents are accounted for; -Nurse I signed for the 3:00 P.M. to 11:00 P.M. shift; -Nurse H signed for the 7:00 P.M. to 7:00 A.M. shift. Observation of the 600 hall on [DATE] at 10:20 A.M., showed: -Entry to the unit from the facility required keypad entry. Door alarm functioned properly; -Resident #1's room at the end of the hall, just before the exit door to the outdoor courtyard. A chair placed in the area between the exit and Resident #1's room; -Exit from the unit to the outdoor courtyard required keypad entry. Door alarm functioned properly; -The 600 hall outdoor courtyard fully enclosed by a wooden fence, over 6 feet high; -Chairs placed in the middle of the grass in the courtyard. Observation of the resident on [DATE], showed: -At approximately 10:20 A.M., he/she stood at the medication cart on the 600 hall, yelling profanities. He/she wore pajama pants and a t-shirt with a hospital bracelet on one wrist. Minutes later, he/she sat in the indoor smoking room, yelling profanities at him/herself; -At 10:50 A.M., the resident lay in bed in his/her room and said he/she was not here right now. During an interview on [DATE] at approximately 10:25 A.M., CNA J said two staff should be assigned to the 600 hall at all times. Smoke breaks are four times a day and one staff must go outside with the residents and count them as they come in. During the smoke break, the other staff member has to stay on the unit to monitor the other residents. Resident #1 stays in his/her room most of the time. He/she does not usually go outside for smoke breaks and when he/she does, he/she sits in the grass and looks at the sky. Staff is responsible for making sure residents are where they are supposed to be. CNAs complete hourly checks on the residents, which are documented on 1 Hour CNA Intensive Monitoring Check forms. If a resident is not where they are supposed to be, staff must call a Code White to notify other staff of a missing resident. During an interview on [DATE] at approximately 12:10 P.M., CNA M said the 300 hall is also a locked unit for residents. There should be two staff working on the unit, but CNA M was the only one working on the unit that day. Many of the residents on the 300 hall are smokers. At the end of the hall, there is an enclosed courtyard where the residents smoke. Keypad entry is required to exit the unit and enter the courtyard. For smoke breaks, CNA M has to stand at the exit to the courtyard, where he/she can see the 300 hall and the courtyard patio. The rule is residents cannot leave the patio during smoke breaks because staff cannot see them. Several residents on the unit are at risk for elopement. During an interview on [DATE] at approximately 1:42 P.M., the DON said the CNA assigned to a hall is responsible for checking residents hourly, and completing hourly monitoring forms. These forms are reviewed by medical records or the administrative assistants to check for accuracy. Nurses should do rounds every two hours. They are expected to complete their own rounds to verify residents are where they should be. The administrator said approximately 19 out of 21 residents on the 600 hall are smokers. During an interview on [DATE] at 10:02 A.M., CNA A said the 600 hall required two staff at all times because anything can happen when there is one person. All of the residents on the 600 hall have behaviors or significant mental health issues. Thirteen out of 21 residents on the 600 hall smoke. The facility is short-handed, requiring staff to work 16 hour shifts. After ,[DATE] shifts, people are basically brain dead. On [DATE], CNA A had just done three double shifts in a row and was scheduled on the 600 hall from 7:00 A.M. to 3:00 P.M., and from 3:00 P.M. to 11:00 P.M. During the day shift, Resident #1 was frustrated and said he/she wanted to go home, so CNA A requested the CMT give the resident a PRN medication. During the evening shift, CNA A was the only person assigned to the 600 hall. MA L came to the hall to help watch the residents who remained inside during smoke breaks. For the last smoke break of the day, CNA A passed cigarettes to the residents as they exited to the courtyard, and then went outside with them to supervise. Resident #1's room is right next to the exit door, so he/she is the first one called for smoke breaks. He/she usually goes outside with the other residents for smoke breaks. When the break was over, CNA A thought he/she saw Resident #1 go back inside, but made a mistake. CNAs should monitor the residents every hour, but CNA A did not double check to make sure Resident #1 was back in his/her room before his/her shift ended at 11:00 P.M. When CNA A arrived for work on [DATE] at 6:30 A.M., staff said the resident was missing. He/she must have gotten on top of the furniture (an old dresser, chairs, and beds) stacked against the fence in the 600 hall courtyard in order to climb over the fence. The furniture had been stacked against the fence for a month or so. The fence around the courtyard is too high for someone to jump over. During an interview on [DATE] at 11:10 A.M., the administrator said surveillance footage from [DATE] could not be provided because the footage erases over itself. She had time to watch it after the incident, but now the footage was gone. Review of the resident's narcotic record, showed: -An order, dated [DATE] for [MEDICATION NAME] (anti-anxiety medication) 2 mg, three times daily PRN; -Administered on [DATE] at 8:00 A.M. and 8:00 P.M. Observation and interview on [DATE] at 8:09 A.M., showed Resident #1 face down on the bed in his/her room. The resident said he/she smokes cigarettes and likes to go outside. The other day, he/she got left outside and that's when (he/she) died . He/she could not remember what happened next. He/she has jumped the fence in the courtyard one time. He/she could not remember where he/she went, but that's when (he/she) died . During an interview on [DATE] at 10:03 A.M., the administrator said Resident #1 was with the facility before and was more independent. His/her family became guardian and removed him/her from the facility and took him/her off his/her medications a year or so ago. When Resident #1 returned to the facility, he/she was no longer appropriate for general population because he/she was a different person and staff needed to get to know him/her again. His/her PASRR indicated it would be safer for the resident to be on the locked unit rather than in the general population. He/she does not do well with larger environments. Placement on the locked units is based on the individual resident. Residents are placed on the locked unit because of elopement risk, behaviors, or because they function better in smaller settings.

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) Resident #1 was not an elopement risk prior to [DATE], but now he/she is. At this time, a copy of the facility's policy about locked unit placement was requested. During an interview on [DATE] at approximately 10:10 A.M., CNA C said he/she was not working on [DATE], when Resident #1 was left outside, but did hear about it. Resident #1 said he/she jumped over the 6 foot wooden fence by running and jumping onto it. CNA C believes the resident because he/she is good at basketball and wrestling. The resident does not want to be at the facility and wants to be home with his/her family. Staff never know what they will get from the resident; one minute he/she is happy, and the next minute he/she is crying. CNA C has not seen any stacks of furniture in the courtyard that could have been used by Resident #1 to jump the fence. Staff on the 600 hall should be doing visual face checks with the residents every 15 minutes or every hour. During an interview on [DATE] at 10:14 A.M., Nurse H said he/she started work at 7:00 P.M. on [DATE], and was not assigned to the 600 hall until 11:00 P.M. He/she helped pass snacks on the 600 hall before 9:00 P.M. and saw Resident #1 in his/her room, in bed. During report, Nurse H did not receive any information that Resident #1 expressed ideations of leaving that day. If the resident made statements about wanting to leave, this should have been communicated to the nurse. CNAs are on the locked units at all times, so Nurse H relies on them to monitor the residents. CNAs should be doing 15 minute and hourly face checks on the residents. Nurses should be doing hourly face checks as well; however, he/she did not do hourly face checks on the night of [DATE] because he/she was relying on the CNAs to monitor. During an interview on [DATE] at 10:24 A.M., Nurse I said on the evening of [DATE], he/she was assigned to three halls, two of which are locked units, including the 600 hall. That night, the facility was short-staffed and things were hectic. Nurse I performed CNA duties on the 200 hall, which had one CNA assigned to it. He/she also helped dietary prepare meal trays because the kitchen was short-handed. CNA A and MA L were assigned to the 600 hall. The CNA should have been doing hourly face checks with the residents by checking off the monitoring sheet after physically laying eyes on the residents. CNA A should have ensured all residents were accounted for during rounds. If a resident did not come back inside after a smoke break, but the monitoring was checked off, the documentation is not accurate. Nurse I relies on the CNAs to be his/her eyes and ears on the halls. He/she trusted CNA A was ensuring residents were where they should be. Nurses should also do hourly face checks and utilize the monitoring checklist. He/she did not check that all residents on the 600 hall were accounted for on [DATE] because he/she assumed the CNA was monitoring the hall like he/she should be. When Nurse I received report on [DATE], staff did not report any issues with Resident #1, such as voicing the desire to leave. If a CNA hears a resident make such a comment, it is expected that they report it to the nurse, so they can take appropriate action. During an interview on [DATE] at 8:41 A.M., CNA K said he/she usually works on the 600 hall. On [DATE], he/she worked a double and was assigned to the 600 hall for the night shift, 11:00 P.M. to 7:00 A.M. When his/her night shift started, there were supposed to be two aides on the 600 hall. CNA K thought there were already two staff on the 600 hall, so he/she worked on a computer off the unit. He/she returned to the 600 hall around 1:00 A.M. or 2:00 A.M., and found out that one of the aides had been moved to a different hall. CNA K forgot his/her clipboard with the hourly monitoring checklist and ended up doing something else instead of hourly face checks on the residents. At around 7:00 A.M., he/she went to fill out the hourly monitoring sheet and found another employee had already filled it out. Shortly after, the CMT arrived on the unit and staff discovered the resident was missing. When CNA A let the residents out to smoke on the evening of [DATE], it was probably too dark to see Resident #1 was still outside. CNAs should be doing hourly face checks with the residents, which means physically laying eyes on them. To his/her knowledge, Resident #1 does not have a history of elopement. During an interview on [DATE] at 10:50 A.M., the Medical Director said if the facility implements hourly checks on residents, it is expected that staff follow through with completing the checks. It is unacceptable for staff to falsify documentation of hourly checks. NOTE: At the time of the abbreviated survey, the violation was determined to be at the immediate jeopardy J level. Based on observation, interview and record review, completed during the onsite visit, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the D level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action to be taken to address Class I violation(s). MO 233
F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, and in accordance with the Center for Disease Control (CDC) guidelines for the 2019 Novel Coronavirus Disease (COVID-19), the facility failed to protect residents in the facility by not following acceptable infection control practices for COVID-19. The facility failed to follow their policy and/or CDC guidelines for how residents in the facility who develop COVID-19 will be handled. One resident who tested positive for COVID-19 had a roommate with a COVID-19 status of unknown (Resident #2 and #3). Facility staff failed to post signage outside the resident's room to indicate transmission based precautions and/or the type of personal protective equipment (PPE) needed. The resident positive for COVID-19 and the resident with an unknown COVID-19 status were located in their room within 6 feet of each other and neither wore a mask. The residents remained in the same room from 8/20/20 when the first positive test results came back and continued to remain in the room until 8/21/20, when brought to the facility's attention by the state surveyor. The facility failed to utilize a space in the facility dedicated to care for residents with confirmed COVID-19 that was separate from residents negative for COVID-19 to include proper signage to identify the area as isolation and/or what PPE was required in the area, for one resident positive for COVID-19 (Resident #6). In addition, the facility failed to follow their policy and ensure staff disinfected a multi-resident use Hoyer lift (mechanical total lift) before or after use (Resident #9). The census was 140. The administrator was notified on 8/21/20 at 3:53 P.M. of an Immediate Jeopardy (IJ) which began on 8/20/20. The IJ was removed on 8/25/20, as confirmed by surveyor onsite verification. Review of the CDC Preparing for COVID-19 in Nursing Homes, updated 6/25/20, showed: -Given their congregate nature and resident population served (e.g., older adults often with underlying chronic medical conditions), nursing home populations are at high risk of being affected by respiratory pathogens like COVID-19. As demonstrated by the COVID-19 pandemic, a strong infection prevention and control (IPC) program is critical to protect both residents and healthcare personnel (HCP); -Regularly review CDC's Infection Control Guidance for Healthcare Professionals about COVID-19 for current information and ensure staff and residents are updated when this guidance changes; -Educate and train HCP, including facility-based and consultant personnel and volunteers who provide care or services in the facility; -Provide supplies necessary to adhere to recommended infection prevention and control practices: Position a trash can near the exit inside the resident room to make it easy for staff to discard PPE prior to exiting the room or before providing care for another resident in the same room; -Identify space in the facility that could be dedicated to monitor and care for residents with COVID-19: -This could be a dedicated floor, unit, or wing in the facility or a group of rooms at the end of the unit that will be used to cohort residents with COVID-19; -Have a plan for how residents in the facility who develop COVID-19 will be handled (e.g., transfer to single room, implement use of Transmission-Based Precautions, prioritize for testing, transfer to COVID-19 unit if positive). Review of the CDC Responding to Coronavirus (COVID-19) in Nursing Homes, updated 4/30/20, showed: -Considerations for establishing a designated COVID-19 care unit for residents with confirmed COVID-19: -Determine the location of the COVID-19 care unit and create a staffing plan before residents or HCP with COVID-19 are identified in the facility. This will allow time for residents to be relocated to create space for the unit and to identify HCP to work on this unit. Facilities that have already identified cases of COVID-19 among residents but have not developed a COVID-19 care unit, should work to create one unless the proportion of residents with COVID-19 makes this impossible (e.g., the majority of residents in the facility are already infected); -Ideally the unit should be physically separated from other rooms or units housing residents without confirmed COVID-19. Depending on facility capacity (e.g., staffing, supplies) to care for affected residents, the COVID-19 care unit could be a separate floor, wing, or cluster of rooms; -To the extent possible, restrict access of ancillary personnel (e.g., dietary) to the unit; -Place signage at the entrance to the COVID-19 care unit that instructs HCP they must wear eye protection and an N95 or higher-level respirator (or facemask if a respirator is not available) at all times while on the unit. Gowns and gloves should be added when entering resident rooms; -Resident with new-onset suspected or confirmed COVID-19: -If the resident is confirmed to have COVID-19, regardless of symptoms, they should be transferred to the designated COVID-19 care unit; -Roommates of residents with COVID-19 should be considered exposed and potentially infected and, if at all possible, should not share rooms with other residents unless they remain asymptomatic and/or have tested negative for [DIAGNOSES REDACTED]-CoV-2 14 days after their last exposure (e.g., date their roommate was moved to the COVID-19 care unit). Review of the facility's pandemic Coronavirus plan, updated on 4/30/20, showed: -Purpose: To provide a plan for surveillance and

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) detection of the presence of pandemic Coronavirus in the facility. To ensure proper containment and treatment of [REDACTED]. The facility will follow physician's orders [REDACTED]. Resident's that test positive for the Coronavirus will be placed on isolation; -How does Coronavirus spread: Person to person and transmission between persons with someone who is infected and those secretions, such as droplets in a cough or sneeze but can also be spread through contact. Infected surfaces or objects such as touching a surface or object that has been infected with [MEDICAL CONDITION]; -Treatment: Droplet isolation- the resident should be placed in on isolation with any potential cases of Coronavirus until transported to an acute care setting. Review of the facility's undated infection control isolation room/COVID-19 policy, showed: -Purpose: To ensure in the event a resident becomes infected or is admitted with [MEDICAL CONDITION] is isolated away from others to prevent the spread of [MEDICAL CONDITION]; -Procedure: -The resident will be taken to the isolation room away from others where he/she will be further assessed; -The room designated in the facility is room [ROOM NUMBER]; -All managers will be notified as well as staff immediately and given further instructions on caring for the resident; -All staff will be in serviced as to what to do in the event they have to enter the room; -The proper barrels needed will be placed in the room so that all trash and linen can be placed in them before leaving the room; -The resident will remain in isolation for the duration of the period as ordered by the resident's physician and the CDC; -This procedure will stand for all residents that return or come from the hospital with the signs or symptoms whether they have the [MEDICAL CONDITION] or if attempting to rule [MEDICAL CONDITION] out. 1. Review of Resident #2's medical record, showed: -[DIAGNOSES REDACTED].M., this writer started at 7:00 P.M. on 8/7/20. Was told resident had a temperature of 101.0. Also, had non-productive cough. Was told the physician was contacted and new order was given for cough medication; -A progress note, dated 8/20/20 at 10:09 P.M., resident resting in bed. Remains on isolation precautions related to COVID-19; -A COVID-19 test result, collected on 8/17/20 and dated 8/20/20 at 1:19 P.M., showed [DIAGNOSES REDACTED]-Cov-2 (COVID-19) detected; -A care plan, printed 8/21/20 and in use at the time of the abbreviated survey, showed: -Problem: Resident tested positive for COVID-19 and at this time is not exhibiting any symptoms of the disease; -Goal: To prevent the spread of infection; -Approaches included: -Isolation for 14 days, then re-test; -Monitor for temperature, shortness of breath, cough, runny nose, sore throat, etc. and report to physician promptly; -Staff/resident to wear mask; -Staff to wash hands before and after entering and leaving resident's room; -Resident to stay in room, requires redirection; -Staff to use infection control equipment in room; -Discard infection control equipment in barrels before leaving room and wash hands; -Educate staff and resident on infection control and why needed. During an interview on 8/21/20 at 8:30 A.M., the administrator said the facility received Resident #2's COVID-19 test results on 8/20/20, and he/she was positive for COVID-19. His/her roommate is Resident #3. Both residents will be placed on isolation together. Resident #3 was tested for COVID-19 on 8/20/20. At this time, the facility's infection control policy that addresses the different types of isolation and what PPE is required were requested. Review of Resident #3's medical record, showed: -[DIAGNOSES REDACTED]. Observation of the 100 hall on 8/21/20 at 9:02 A.M., showed: -Four signs posted on the double doors entering the 100 hall; -Wash hands; -No phone zone; -Stop if you have symptoms; -List of COVID-19 symptoms; -No signage regarding transmission-based precautions or PPE required; -A three-drawer caddy outside the double doors entering the 100 hall, contained a box of gloves, shoe covers, gowns, and two pairs of protective eye wear; -Certified Medication Technician (CMT) B stood at a medication cart in front of the 100 hall dining room on the inside of the double doors. He/she wore a gown, shoe covers, and surgical mask. During an interview on 8/21/20 at approximately 9:03 A.M., CMT B said shoe covers, goggles, and a gown should be worn on the 100 hall because Resident #2 tested positive for COVID-19. Observation of the room shared by Resident #2 and Resident #3, on 8/21/20 at approximately 9:08 A.M., showed: -The door to the room fully open; -No signage regarding transmission based precautions or PPE usage on the resident's door or outside of the room; -No PPE located outside of the resident's room; -Resident #2 seated on his/her bed, talking to self, and not wearing a mask; -Resident #3 seated on a chair next to Resident #2's bed, not wearing a mask, and approximately 4 feet away from Resident #2. Observation and interview on 8/21/20 at approximately 9:10 A.M., showed CMT B wore a surgical mask, gown, and shoe covers. He/she said the doors entering the 100 hall should have signs posted regarding PPE use and precautions. Outside of the room shared by Resident #2 and Resident #3, signs should be posted to notify staff if a resident is on isolation and what PPE is required. CMT B knew about Resident #2's positive COVID-19 test and what PPE to wear because staff told him/her. During an interview on 8/21/20 at 10:50 A.M., the facility's Medical Director (MD) said she saw Resident #2 a week ago. He/she previously had a cough that had improved, and his/her lungs were clear with no noted respiratory problems. The MD ordered the resident be tested for COVID-19, and the results were positive. Facility administration notified the MD of the positive test results on 8/20/20. During their conversation, the MD discussed moving Resident #2 to another room, or moving his/her roommate, Resident #3, who had not tested positive for [MEDICAL CONDITION]. The MD did not know the residents still remained in the same room. During her discussion with facility administration on 8/20/20, the MD recommended testing all residents on the 100, 200, and 300 halls for COVID-19, and a 14-day quarantine for residents with suspected cases. The facility declined her recommendations and will only be testing symptomatic residents. Most residents on the 100 hall are ambulatory and should wear masks when they are in the hall. Resident #2's room is on the 100 hall, but due to his/her severe mental [MEDICAL CONDITION], he/she will not wear a mask. The 100 hall should be made into an isolation unit to prevent the spread of COVID-19. Signs should be posted outside the rooms of any resident on precautions, and on the doors of the unit where precautions must be taken. Signs on the rooms and halls should show staff what PPE is required. Staff working on an isolation unit should wear N95 masks, face shields, gowns, and gloves when providing care. The facility should be following its infection control policies. During an interview on 8/21/20 at 11:26 A.M., the administrator and Director of Nursing (DON) said when a resident tests positive for COVID-19, they are placed on contact isolation in their rooms, and are not permitted to leave their room while on isolation. Droplet precautions are also implemented and staff should wear N95 face masks, gowns, face shields, gloves, and shoe covers while on an isolation unit. The 100 hall has been made into an isolation unit and there are now caddies containing PPE outside of the room where the resident tested positive for COVID-19. Signs should be posted on the hall and outside of the rooms where droplet precautions are implemented, to inform staff of what PPE is required. One resident, Resident #6, is already on isolation on the 200 hall after testing positive for COVID-19. The physician ordered Resident #2 be tested for COVID-19 due to a cough he/she had three weeks ago. It would be detrimental to move Resident #2 to the 200 hall because he/she would not have stayed in the room and would have fought with staff about moving. It was easier to keep him/her in his/her room. There were no other rooms on the 100 hall open. This is the first time the facility has had a positive COVID-19 case, so staff need to be educated on what type of transmission based precautions are needed and what to do if a resident tests positive. When asked what was being done to protect Resident #3 from getting COVID-19 from Resident #2, the administrator and DON said the residents have been roommates for a long time, and Resident #3 probably already has it. At this time, a copy of the facility's infection control policy that addresses the different types of isolation and what PPE is required was again requested. Review of the facility census report, showed room [ROOM NUMBER] identified as an isolation room and showed it was empty. During an interview on 8/21/20 at 2:55 P.M., the DON said she was not aware the resident had the temperature or non-productive cough documented in the progress notes, she would have to look further into that. She was surprised when the doctor wanted Resident #2 tested for COVID-19. When she asked the doctor why they were obtaining the test, the doctor said because the resident had a cough a while back. During an interview on 8/21/20 at 3:26 P.M., the administrator said Resident #6 is already on isolation after testing positive for COVID-19. If Resident #2 was moved into the same room, Resident #6 would try to take care of him/her and the two residents would not be compatible as roommates. Resident #2's roommate, Resident #3, has declined cognitive ability and requires monitoring when eating. Moving him/her to another room could potentially cause him/her to stop eating. Residents #2 and #3 have been roommates for a very long time. Both of them were placed on isolation together and Resident #3's COVID-19 test is pending. During an interview on 8/21/20 at 4:20 P.M., the DON said staff was in the process of moving Resident #2 to Resident #6's room. Resident #3 will remain in his/her room. The facility has started in-servicing staff in the building regarding precautions for COVID-19 and isolation. Further review of Resident #3's medical record, showed: -A nurse's note, dated 8/20/20 at 3:14 P.M., showed a call placed to the resident's family regarding COVID-19 test results on a different resident in the facility. A call placed to the physician and new order received to test Resident #3 for COVID-19. Test completed and resident showed no signs/symptoms of [MEDICAL CONDITION]; -A COVID-19 test result, collected on 8/20/20 and approved by the lab on 8/24/20 at 2:46 A.M., showed [DIAGNOSES REDACTED]-Cov-2 not detected. During an interview on 8/25/20 at approximately 11:05 A.M., the administrator and DON said Resident #3's COVID-19 test results came back negative for [MEDICAL CONDITION]. Resident #2's positive COVID-19 results were not received until the evening shift on 8/20/20. He/she was not moved to another room on the 100 hall because there were no empty rooms available. After receiving

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265823	A. BUILDING _____ B. WING _____	08/26/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CRESTWOOD HEALTH CARE CENTER, LLC	11400 MEHL AVENUE FLORISSANT, MO 63033

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) Resident #2's results, the DON had to prepare the 100 hall as an isolation unit before she had time to post signs regarding droplet precautions and PPE requirements. As of the abbreviated survey exit, on 8/26/20, no policies that address the different types of isolation and what PPE is required had been provided by the facility. 2. Review of Resident #6's medical record, showed: -[DIAGNOSES REDACTED]. Review of the care plan, printed 8/21/20, and in use at the time of the abbreviated survey, showed: -Problem: The resident tested positive for COVID-19. He/she had no symptoms; -Goal: Prevent the spread of the infection; -Approaches: Isolate the resident for 14 days, monitor his/her temperature, shortness of breath, runny nose, changes in taste or smell and report changes to his/her physician, staff and the resident to wear a mask, the resident to stay in his/her room and staff to redirect, infection control equipment inside of the resident's room, staff to discard equipment used in barrels inside of the room before leaving the resident's room. During the entrance conference on 8/19/20 at 9:25 A.M., the Administrator said Resident #6 tested positive for COVID-19. The resident had been tested because a physical therapy assistant tested positive outside the facility and that staff member worked on the resident's hall. All of the residents on the 300 hallway were tested and when Resident #6's COVID-19 test results were reported as positive, the staff moved him/her to a room at the end of the 200 hall, the room is used and identified as the facility's isolation room. The facility retested the resident on 8/17/20. At the time of the entrance conference, the resident's second test results were not available. Observation on 8/19/20 at 10:20 A.M., of the 200 hallway, showed: -In the hall outside of the resident's room, a metal portable linen cart with an 8 x 11 yellow piece of paper on the lid, showed infectious linen; -A red plastic biohazard container located in the hallway, outside the resident's room; -On the resident's closed door, an 8 x 11 piece of paper showed Stop, contact precautions. Everyone must clean hands, when entering or leaving the room, apply gown and gloves at the door and use patient dedicated or disposable equipment, leave used material in the room and keep the door closed; -A three drawer isolation caddy outside of the room contained disposable gowns, gloves and red biohazard trash bags; -No defined COVID-19 care area and/or no signage at the entrance to the COVID-19 care area that instructs HCP they must wear eye protection and an N95 or higher-level respirator (or facemask if a respirator is not available) at all times while in the area and that gowns and gloves should be added when entering resident rooms. Numerous residents noted to walk the length of the hallway, past the resident's room and past the biohazard trash can and bin. During an interview on 8/19/20 at 10:30 A.M., the facility's Medical Director said the facility had one resident that had a positive COVID-19 test result. The resident had no signs or symptoms and the facility retested him/her and the results were not back yet. Used isolation PPE barrels should not be in the hallway, the barrels should be inside of the isolation room to prevent potential infection spread. Several of the resident's in the facility wander the hallways and could easily touch the isolation barrels if the barrels are exposed in the facility hallways. Further observation of the resident's room on 8/19/20, showed: -At 12:10 P.M., Resident #6 opened his/her room door, he/she did not wear any mask, exited the room into the hallway and placed used linen from his/her room into the yellow infectious linen cart in the hallway. Licensed Practical Nurse (LPN) G wore a cloth face mask, not the required N95 or higher-level respirator or facemask if a respirator is not available, approached the resident in the hallway and told the resident he/she may not be in the hallway without a mask in place. The resident went into his/her room and closed the door; -At 12:55 P.M., the biohazard barrel and infection linen cart remained in the hall outside the resident's room. Three residents walked the length of the hallway, past the biohazard barrel and infection linen cart. No signage posted identifying the area as an isolation area. During an interview on 8/19/20 at 1:45 P.M., the DON said all isolation disposal barrels should be in the isolation room and not in the hall. If the barrels are exposed in the hallways, other facility residents could potentially touch the barrels and contract the illness. The facility had several residents that walked the hallways. 3. Review of the facility's undated multiuse equipment policy, showed: -Any equipment being used on more than one resident must be sanitized between each resident; -Electronic lifts: Staff should use chemical in the spray bottle to spray and wipe the lifts down between resident uses. Review of Resident #9's medical record, showed: -Severe cognitive impairment; -Total staff assistance needed for transfers and daily care; -Used a mechanical lift for all transfers; -[DIAGNOSES REDACTED]. Observation and interview on 8/19/20 at 11:16 A.M., showed CNA D and E obtained the Hoyer lift from the hallway and pushed the lift to the resident's bedside. The CNAs attached the Hoyer lift to the lift pad and transferred the resident into his/her chair. The Hoyer lift was not sanitized prior to transferring the resident. CNA D pushed the Hoyer lift into the hallway along the wall and re-entered the resident's room. CNA E walked out of the resident's room and exited the unit. He/she did not sanitize the lift before leaving the unit. CNA D exited the resident's room and entered a separate resident's room. LPN F entered into the resident's room to provide care, and left the resident's room. He/she said all lifts should be disinfected before and after resident use. The disinfectant is in the hallway bathrooms. The facility had been short staffed and the CNAs may have forgotten to wipe down the lift before moving on to care for other residents. During an interview on 8/19/20 at 11:20 A.M., CNA D said the facility had been short staffed. He/she forgot to wipe off the lift before or after use. CNA E assisted him/her with the resident's transfer, but CNA E had not been assigned to the hallway. The disinfectant that should be used on the lifts is in the hallway bathroom, but he/she did not have time to clean the lift related to being short staffed and he/she needed to assist other residents. During an interview on 8/19/20 at 1:45 P.M., the DON said all lifts should be disinfected and sanitized before and after each resident use. The disinfectant should be easily accessible to staff. NOTE: At the time of the abbreviated survey, the violation was determined to be at the immediate jeopardy J level. Based on observation, interview and record review, completed during the onsite visit, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the D level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action to be taken to address Class I violation(s).