STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465083	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestwood Rehabilitation and Nursing	3665 Brinker Avenue Ogden, UT 84403

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50200 Based on interview and record review, it was determined that in response to allegations of abuse, neglect, exploitation, or mistreatment, the facility failed to report the results of all investigations to the State Survey Agency (SSA), within 5 days of the incident. Specifically, for 2 out of 7 sampled residents, the facility did not thoroughly investigate an allegation of abuse from misappropriation of funds and an allegation of neglect from a fall with serious injury. Resident Identifiers: 1 and 2. Findings include: 1. Resident 1 was admitted to the facility on [DATE] with diagnoses which included quadriplegia, muscle weakness, chronic obstructive pulmonary disease, sepsis, and cellulitis. On 5/1/24, resident 1's medical record was reviewed. Exhibit 358 Initial Report dated 2/28/24 at 4:49 PM, indicated that the facility reported an incident to the SSA. The initial report indicated an allegation of misappropriation of funds and exploitation when resident 1's money from his wallet went missing. On 5/1/24 at 12:22 PM, an interview was conducted with the Resident Advocate (RA). The RA stated that resident 1's missing money was reported as abuse to the Administrator. The RA stated that no grievance form was filled out by the resident. The RA stated that resident 1 stated that he had his wallet in his pocket that morning. The RA stated that the wallet was found in the dining room by either maintenance or housekeeping with no money. The RA stated that there was a policy that stated that residents were to put their valuables in a safe or a facility managed fund account. The RA stated that resident 1 signed the policy about not having his money compensated by the facility with all of his admission paperwork. (continued on next page)

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

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/1/24 at 3:12 PM, an interview was conducted with the Administrator (ADM). The ADM stated that he did review the footage regarding the alleged incident and did not see anything as the cameras only record in 30 second intervals. The ADM stated that he did replace the resident's money and educated the resident regarding keeping his money in the safe. The ADM stated that if he received an allegation of abuse he tried to educate all staff about different types of abuse and how soon you report the abuse. The ADM stated that he had dropped the ball on submitting the 359 form regarding this incident. The ADM stated that the 359 form would include whether the alleged incident was substantiated or not, what measures were taken to keep residents safe, and a general summary of interviews and the incident. The ADM stated that he had 5 days to submit the 359. 2. Resident 2 was admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease, major depressive disorder, schizophrenia, fibromyalgia, and post traumatic stress disorder. On 5/1/24, resident 2's medical record was reviewed. Exhibit 358 Initial Report dated 2/23/24 at 4:49 PM, indicated that the facility reported an incident to the SSA. The initial report indicated an allegation of neglect when resident 2 sustained a fall where serious injury occurred resulting in a lumbar compression fracture. On 2/21/24 at 11:29 PM, an alert note stated, Patient on alert charting following previous unwitnessed fall. Patients vital signs 132/81, 16 RR [respiratory rate], 99.1, 92 HR [heart rate], 90% oxygen on RA [room air]. Patient has had no complaints of pain or discomfort. No new injuries or wounds from fall. Patient at baseline. Will continue to monitor. On 2/22/24 at 12:41 PM, a nurse note stated, X-ray results received and notified MD [medical doctor] with results. New order received to schedule CT [computed tomography] scan for back r/t [related to] fall on 2/21/24 to rule out fracture. Transportation notified of scheduling need. No other new orders at this time. On 2/22/24 at 3: 30 PM, a nurse note stated, Res. [resident] is a frail 67yr [year old] old female who had an unwitnessed fall on 02/21/24. Res. is A&O [alert and oriented] x4 [person, place, time and situation] reporting. Xray results received this shift. Medical provider notified and orders CT scan to rule out any fx [fracture] r/t the res. increased pain. Rec [received] scheduled pain medication and PRN [as needed] pain medication which the res. requested this shift with success evidence by res. reporting 3/10 pain at this time. No discoloration of skin noted r/t fall this shift. Res. remained safe this shift. No new concerns. On 2/23/24 at 12:52 PM, a physician not stated, . had a fall 2/21. She complained of low back pain so stat [immediately] lumbar spine xrays were ordered. Results showed compression fractures of indeterminate age. CT scan was ordered and done yesterday. We are awaiting results. Staff charting shows . has not had uncontrolled pain since the fall but she does report having low back pain and wonders if she can get anything stronger than tramadol. Low backpain [sic]- following a fall. Xrays showed Lumbar compression fractures - awaiting CT results to determine if these are new or old. Will order norco 5/325 tid [three times a day] prn. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Crestwood Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 3665 Brinker Avenue Ogden, UT 84403	

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/1/24 at 12:00 PM, a review of the resident 2's CT results revealed an acute to subacute appearing inferior endplate compression fracture of the L2 vertebral body with approximately 20% vertebral body height loss. On 5/1/24 at 12:05 PM, a review of resident 2's care plan initiated on 3/9/23 and revised on 3/20/24, showed the resident was at risk for falls r/t weakness and impaired balance and new compression fracture to lumbar vertebra. Interventions to prevent falls include, using call light when needing assistance, educating the resident on using her walker when ambulating, and staff educated on ensuring the resident has non-slip socks and appropriate footwear. On 5/1/24 at 1:00 PM a review of the facility's investigation into the incident with resident 2 revealed that the ADM interviewed 1 nurse that was on duty at the time of the incident and two CNA's. In addition, the ADM did speak to two residents who were also in the room when the fall occurred. Resident 2 stated in her interview with the ADM that she had stood up to retrieve her cigarettes, lost her balance, and without using her walker fell to the ground. On 5/1/24 at 1:20 PM, an interview was conducted with CNA 1. CNA 1 stated that she did not know who the abuse coordinator was in the facility. CNA 1 stated that if a resident fell she would immediately get the nurse and follow their instructions. CNA 1 stated that she was not familiar with the fall that resident 2 sustained. On 5/1/24 at 1:30 an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that if a fall occurs she reported it to the doctor and the Director of Nursing (DON). LPN 1 stated if she had suspicions of a resident being abused or neglected then she notified the ADM and DON. LPN 1 stated that she did not recall the fall with resident 2. On 5/1/24 at 3:12 PM, an interview was conducted with the ADM. The ADM stated that when abuse or neglect were reported to him he first makes sure the resident was safe and then he started the report and investigation as soon as possible. The ADM stated that he came in on the weekend if an incident occurs. The ADM stated if it was midnight then he waited until the next day to start his investigation. The ADM stated that the 358 form needed to be submitted within 2 hours and the 359 form needed to be submitted within 5 days.

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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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46232 Based on interview and record review it was determined, for 1 of 7 sampled residents, that the facility did not ensure that the discharge needs of the resident was identified and resulted in the development of a discharge plan for the resident; that regular re-evaluation to identify changes that required modification to the discharge plan was completed; and referrals to local agencies for the purpose of returning to the community were documented. Specifically, a resident desired to return to the community through the New Choice Waiver (NCW) program and the facility did not submit the required paperwork for a whole year. Resident identifier: 6. Findings Included: Resident 6 was initially admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses of malignant neoplasm of right renal pelvis, atrial fibrillation, generalized anxiety disorder, major depressive disorder, unsteadiness of feet, and difficulty in walking. On 5/1/24 at 10:02 AM, an interview was conducted with resident 6's Family Member (FM). The FM stated the first time the Resident Advocate (RA) had submitted paperwork to NCW, they had not submitted the proper paperwork and never followed up on it. The FM stated they asked the RA at the beginning of April 2024 to get the NCW application in process again, but they had issues with submitting the paperwork again. The FM stated that so much time had passed between the initial NCW application and the recent one, that the case manager had changed. The FM stated they believed maybe it was a financial benefit for the facility to keep resident 6 there longer. The FM stated a NCW application was supposedly submitted on April 9, 2024 but they were unable to locate the application. The FM stated the RA had re-submitted the application but forgot to check a box that time around. The FM stated the NCW was finally submitted on April 24, 2024 after the Ombudsman came into the facility and talked to the RA. The FM stated they had a location picked but the place would only hold a room for resident 6 until May 31. The FM stated they were concerned resident 6 was going to lose the room that was on hold for them. The FM stated they had recently heard from the case manager that the NCW was in review, and they were just waiting for approval. On 5/1/24 at 11:15 AM, an interview was conducted with resident 6. Resident 6 stated they were unsure where they were at in the NCW process. Resident 6 stated the RA claimed they were working on the NCW but they believed the RA was actually working against them. Resident 6 stated it had been an ongoing process since last year. Resident 6 stated the RA initially told them they had to wait 90 days before they could apply for the NCW but kept on pushing the process back repeatedly 90 days at a time. Resident 6 stated their family member finally got ahold of the RA and asked them about the hold up. Resident 6 stated the RA told the family member; they were told to quit on resident 6's NCW application. Resident 6 stated they were confused as to why someone told the RA to stop their application process. Resident 6 stated they had gotten word that their application had finally been submitted after a year. Resident 6 stated it was unbelievable it had taken that long. Resident 6's medical record was reviewed on 5/1/24. On 4/9/24, a State Optional Minimum Data Set (MDS) documented resident 6 had a Brief Interview for Mental Status (BIMS) score of 10 which indicated resident 6 had moderate cognitive impairment. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The medical record profile revealed resident 6 was their own responsible party. A care plan focus area initiated on 3/17/21 stated as followed, The resident has expressed a desire to return to the community to live with family. A documented intervention included, Resident will have the opportunity to attend care conferences upon admission and at least quarterly to discuss plan of care, discharge plan/goals, questions/concerns, etc. Discharge plan will be revised as indicated. On 12/1/22, an admission care conference summary form documented, [resident 6] has recently asked to apply ofr (sic) the NCW application has been filled out waiting for [resident 6] to choose a case management company. On 9/28/23 at 3:32 PM, a social service note documented, . [resident 6] has talked about moving in with his wife and his daughter [name removed] states this would be a very bad idea and that her mom can barely take care of herself and may be moving to an ALF [assisted living facility]. She stated that if the mom does move that that (sic) would be a better time for [resident 6] to move in with her. She feels the LTC [long term care] is a better fit for her father through. This RA [resident advocate] will approach that conversation with [resident 6] on a day he is more calm. On 4/25/24, a quarterly care conference summary form documented resident 6's quarterly care conference had occurred on 4/1/24. The discharge goal stated resident 6 had applied for the NCW and was planning on moving to an ALF. It documented the resident had not picked an ALF yet but they wanted to move closer to family. It documented resident 6 would discharge home with home health. The provider had been made aware of the plan and agreed with the discharge. It should be noted that there were no documented care conference summaries for the entire year of 2023 to indicate resident 6's discharge goal had been updated or discussed about. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/1/24 at 11:27, an interview was conducted with the RA. The RA stated care conferences were held every quarter and they were conducted for several reasons such as discussing resident goals, updating the care plan, and discussing discharge planning. The RA stated they were done every 3 months which meant residents had a total of 4 care conferences done a year. The RA recognized there was a big gap in between resident 6's last documented care conference on 12/1/22 to their most current one on 4/25/24. The RA stated a resident discharge planning started upon admission, but discharge plans changed throughout the stay. The RA stated they were in charge of submitting the NCW application. The RA stated a resident needed to reside at the facility for 90 days before they were able to apply for the NCW. The RA stated the application was not hard to complete but it was timely to upload the paperwork needed. The RA stated there were times they needed to submit additional documentation once the NCW had been submitted. The RA stated the rate of being accepted into the NCW program depended on how many residents had applied at that time. The RA stated if they took a couple of days to submit the additional documentation requested, then there was a possibility the review process for the NCW was delayed. The RA stated resident 6's goal was originally to stay in LTC but then they asked to apply for the NCW on April 10, 2023. The RA stated at that time the daughter had told the RA to not continue with the NCW for resident 6. The RA stated they had not heard anything from the family about a status change on the NCW process until last month. The RA stated they had issues with submitting resident 6's NCW application last month. The RA stated, when they had initially submitted the first application last month, they were told the application was not found in the system. The RA stated then they re-submitted the application. The RA stated on April 17, 2024, they had been notified that they forgot to check the right box on the form and instead of uploading resident 6's face sheet, they had uploaded the incorrect document. The RA stated two days later they got done what they could. The RA stated they had been made once more that they had accidentally checked the wrong box again and need to resubmit the application. The RA stated the NCW application had finally been submitted on April 24, 2024. The RA stated the day that resident 6's family had notified them of wanting they NCW, the RA stated they were dealing with a family matter that day. The RA stated they were the only ones who had access to the NCW system. The RA stated they understood why resident 6's family was frustrated with the application process since it had taken a few days to complete. The RA stated they had gotten the application submitted as timely as they could. The RA stated resident 6 would not be discharged before May 31 due to their NCW status still being reviewed. The RA stated the NCW needed to have been accepted before the 20th of the month and everything needed to be set in stone for the resident to discharge on the 1st of the following month. On 5/1/24 at 2:46 PM, a follow up interview was conducted with the RA. The RA stated they should have applied for the NCW last year when the resident had initially asked.