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	12/30/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined, for 1 of 19 sampled residents, that the facility did not ensure that each resident received supervision to prevent accidents. Specifically, a resident who was assessed as high risk for exit seeking and had a wanderguard alarm system placed on his body eloped from the facility and was missing for multiple hours. Resident identifier: 1. Findings included: Resident 1 was admitted to the facility on [DATE] with diagnoses which included dementia, alcohol dependence, Wernicke's encephalopathy, osteoarthritis left knee, and chronic pain. On 12/29/25 at 9:53 AM, an interview was conducted with resident 1. Resident 1 stated that he exited the building from the door located inside his room, and the alarm on the inside of the door did not work. The resident was observed to ambulate independently and open the door to the outside courtyard. The courtyard was enclosed by a fence with locked gates on both sides of the courtyard. Resident 1 stated that a long time ago he would leave the facility to go to the store, but now he gets a ride to the store from the facility staff. Resident 1 stated that he had an ankle monitor that was observed located on the resident's right ankle. Resident 1 stated that he did not know why it was on his ankle and staff did not tell him what it was for. Resident 1 stated that it was kind of weird having it on his body but that it did not hurt him. Resident 1's medical records were reviewed on 12/29/25 through 12/30/25. On 12/9/25, resident 1's Annual Minimum Data Set (MDS) assessment documented a Brief Interview for Mental status (BIMS) score of 3, which indicated a severe cognitive impairment. On 12/20/24, resident 1's Montreal Cognitive Assessment (MOCA) score was 6/30, which indicated a severe cognitive impairment. On 12/28/25, resident 1's Functional Abilities and Goals assessment documented that the resident did not utilize any mobility devices and required partial to moderate assistance for mobility. On 12/4/25, resident 1's Wander/Elopement Risk Evaluation documented that the resident currently wandered, had a diagnosis of dementia, had previous attempts at elopement, had a recent history of alcohol or substance abuse, had Short-Term Memory (STM) or Long-Term Memory (LTM) impairments, and had impaired decision making skills. The assessment documented, Resident has had increased wandering and staff has had to redirect resident from exit-seeking more frequently. On 12/8/25, resident 1's Community Safety Evaluation documented that the resident was not evaluated for community safety due to the resident residing in a memory care unit, was high risk for elopement or used a wander guard. On 12/4/25, resident 1 had a physician order for WANDERGUARD: To be used at all times d/t [due to] elopement risk. Device located on (L [left] ANKLE). Verify placement of wander guard q [every] shift. Resident 1's progress notes revealed the following: On 12/4/25 at 2:26 PM, the nursing note documented, resident has been noted to be wondering (sic) more often and has required redirection multiple times. resident to prevent elopement. He is redirectable, though wondering has continued throughout this shift. MD [Medical Doctor] and nurse management is aware and will follow up.On 12/18/25 at 5:56 PM, the nursing note documented, CNA [Certified Nurse Assistant] noted resident lunch tray was untouched and began to look for resident and notified SN [Skilled Nurse] resident did not eat his lunch and was not able to locate him on the hall. CNA notified CNA coordinator, who informed DON [Director of Nursing] immediately. All staff were immediately alerted to participate in elopement protocol to locate resident. The staff immediately searched the building and facility grounds. Resident was found a short distance from the facility grounds. He had no s/sx [signs or symptoms] of injury or change in condition. MD, family notified. On 12/23/25 at 10:16 AM, the Event Note documented, It is the determination of the IDT [Interdisciplinary Team] team, due to staff member turning off the wander guard alarm and not redirecting or notifying another staff member, resident was able to go a short distance from the facility. The note documented that the preventative measures in place prior to the incident was that resident 1 had a wander guard placed on his person. Resident 1's Care Plans revealed the following: On 12/4/25, a care plan was initiated for resident 1 for at Risk for Wandering and Elopement. Interventions identified on the care plan included staff education on elopement policy, engaging resident in purposeful activities, identify triggers for wandering/eloping, and resident 1 will wear a wander guard. On 12/17/24, a care plan was initiated for resident 1 not being safe to access the community independently. Interventions identified on the care plan included that resident 1 would follow the Leave of Absence (LOA) policy when accessing the community with an approved responsible party. On 12/18/25 at 4:22 PM, the facility reported to the State Survey Agency that resident 1 had eloped on 12/18/25 at 2:30 PM. The facility investigation documentation for the elopement was reviewed. The summary of interviews documented that a

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review it was determined, for 3 of 19 sampled residents, the facility did not provide each resident with food that was palatable, attractive, and at a safe and appetizing temperature. Specifically, residents complained of food quality, the test tray was not attractive or palatable, and there were complaints in the resident council meetings. Resident identifiers: 2, 16, and 17. Findings include:On 12/29/25 at 11:51 AM, an interview was conducted with resident 17. Resident 17 stated the food tasted like shit. Resident 17 stated They could starve a bird with the food they serve here. Resident 17 stated he was served only a piece of toast and coffee for breakfast yesterday. On 12/29/25 at 1:39 PM, an interview was conducted with resident 2. Resident 2 stated the food was served cold. On 12/30/25 at 11:07 AM, an interview was conducted with resident 16. Resident 16 stated the food was not good and she did not eat lunch on 12/29/25. Resident 16 stated it was popcorn chicken with all breading and it looked horrible. Resident 16 stated she did not eat anything for lunch. On 12/29/25 at 12:27 PM, an observation was made of the trayline during lunch. [NAME] 1 was observed to plate the food and then put a plate into a base. At 12:41 PM, [NAME] 1 was observed to use a hot pellet under a plate. [NAME] 1 stated they were out of bases. At 12:45 PM, the last tray was plated for the 200 hallway. At 12:48 PM, the meal cart was set outside the kitchen with resident meals and the test tray. At 12:58 PM, the last tray was served to residents and the test tray temperatures were obtained. The tray had brussel sprouts that were dark green/brown colored, popcorn chicken was brown, and the rice was white. There was a yellow colored dessert served and a roll in a baggie. The following temperatures were obtained from the test tray: [Note: All temperatures were in degrees Fahrenheit.] a. The popcorn chicken was 97.5 and cold to the taste. It was hard on the outside with lots of breading and hard to chew. b. The rice was 98.6 and cold to the taste.c. The brussel sprouts were 94.1 with a brown/dark green in color with a mushy texture. The brussel sprouts were cold to the taste. d. The dessert was 63.8. The dessert was pineapple with a cinnamon crumble top. The dessert's flavor had a strange combination of flavors. Resident council minutes from 1/7/25, 2/4/25, 3/5/25, and 5/6/25, there were complaints of cold food. On 6/3/25, the concerns being followed up on did not have cold food as a concern. On 12/30/25 at 11:30 AM, an interview was conducted with [NAME] 2. [NAME] 2 stated the plates were warmed and put into the liner with a dome over the top when serving food. [NAME] 2 stated there were not enough liners, so pellets were used when the cooks ran out of the liners. [NAME] 2 stated that pellets were not used with the plastic liners. [NAME] 2 stated the pellets were warmed and got really hot but by the time the pellet was provided to the resident it was cool enough to touch. On 12/30/25 at 12:28 PM, an interview was conducted with the Dietary Supervisor (DS). The DS stated kitchen staff should use a liner/base, then a pellet in the base, the plate, and a dome over the top of it. The DS stated the pellets should not be used without the liner/base. The DS stated there were not enough bases for all the residents in the facility. The DS stated the pellets were used to hold in heat and should be warmed to the point that staff could not touch them. The DS stated there were complaints of cold food but then there was staff turnover in the kitchen and in the last 5 months there have not been as many food complaints.

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. Based on observation, interview, and record review, it was determined the facility did not provide drinks, including water and other liquids consistent with resident needs and preferences and sufficient to maintain resident hydration. Specifically, a sign was hung in the elevator instructing residents that water was the only beverage available between meals and coffee was served at specific times. Findings include: On 12/30/25, a sign was observed in the resident elevator. The sign revealed UPCOMING CHANGES!!! COFFEE WILL NOW START BEING SERVED AT 7 am AT THE EARLIEST COFFEE AND JUICE WILL ONLY BE SERVED AT MEAL TIMES AND WE ARE NO LONGER FILLING UP MUGS WITH JUICE OR COFFEE! IF YOU WANT TO HAVE ANY BEVERAGES BESIDES WATER BETWEEN MEAL TIMES YOU WILL HAVE TO PROVIDE YOUR OWN (WE ARE IN THE PROCESS OF GETTING VENDING MACHINES). THIS WILL BEGIN ON MONDAY NOVEMBER 17TH!!! On 12/30/25 at 12:28 PM, an interview was conducted with the Dietary Supervisor (DS). The DS stated recently there was a policy change that residents were not provided beverages other than water between meal times. The DS stated residents were not allowed to bring their mug to be filled with coffee or juice to the kitchen because of cross contamination concerns. The DS stated they prepoured drinks for meals and put them on the meal tray. The DS stated if a resident asked for something between meals it was against policy to provide it. The DS stated that started at the beginning of November and since implementing that residents have complained. The DS stated coffee was not available all day but if a Certified Nursing Assistant (CNA) asked the kitchen staff for coffee for a resident, then the kitchen staff would get it for the resident.