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	04/27/2026

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 - Actual harm 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, for 1 of 40 sampled residents, the facility did not ensure that each resident received adequate supervision and assistance devices to prevent accidents. Specifically, a resident developed a shearing injury related to a Hoyer lift transfer. This will be cited at a Harm level at past non-compliance with a completion date of 3/6/26. Resident identifier: 10. Findings included: Resident 10 was admitted to the facility on [DATE] with diagnoses which included unspecified fracture of right lower leg, paraplegia, cirrhosis of liver, rhabdomyolysis, and mild protein-calorie malnutrition. On 4/22/26 at 3:04 PM, an interview was conducted with resident 10, who stated that he had been cut on the buttocks during a Hoyer lift transfer by a new Hoyer sling, which had sharper edges than his previous sling. Resident 10 stated that after the initial injury the sling was replaced. Resident 10 stated that the wound had been painful. On 3/12/2026 at 4:18 PM, a nursing progress Event Note documented: Event Description: On 3/6/2026 as the Skilled nurse [SN] was completing a weekly skin assessment, skin breakdown was noted to resident buttocks. SN contacted nurse management and assessment of wound noted. Resident noted to have breakdown on right buttock, and shearing injury related to Hoyer sling being removed by CNA [Certified Nursing Assistant]. Contacted MD [Medical Director] and wound NP [Nurse Practitioner] for orders and to review interventions. The Event Note Template documented that resident 10 was at risk for a breakdown in skin integrity and that it is the determination of the IDT [interdisciplinary team] that improper removal from under the resident of the Hoyer sling caused friction and shearing injury. On 4/22/26 at 3:13 PM, an interview was conducted with Certified Nursing Assistant (CNA) 2. CNA 2 stated that two CNAs always performed Hoyer transfers and assisted resident 10 in gently rolling from side to side to remove the Hoyer sling. CNA 2 stated that resident 10 typically tolerated transfers well, but he had recently mentioned an injury sustained during a Hoyer transfer. CNA 2 stated that the facility had recently conducted training on Hoyer transfers, which included the proper technique for rolling the resident side-to-side when placing and removing a Hoyer sling. On 4/22/26 at 4:52 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that the Assistant Director of Nursing (ADON) 1 informed her of resident 10's wound on 3/6/26, and then they telephoned resident 10's physician and Wound Care Provider (WCP) to obtain orders. The DON stated that while the resident and the CNA staff present when the injury occurred were interviewed she did not know if they had documentation of the interviews. The DON stated that through interviews, assessment, and discussions with the WCP, they determined the wound was a shearing injury sustained when staff incorrectly removed a Hoyer sling from under the resident. The DON stated that resident 10's physician ordered Vitamin C and a nutritional supplement, and the WCP provided wound care orders. Additionally, the DON stated that after it was determined that improper removal of the Hoyer sling caused the shearing injury, she collaborated with the CNA Coordinator to train the staff working that day. The DON stated that they later provided an in-service to staff which covered the proper removal of a Hoyer lift sling after use. Additionally, the DON stated that the facility completed Hoyer sling removal skills checks and observation audits with the CNAs. On 4/24/26, the facility (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465083	A. Building B. Wing	04/27/2026

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 - Actual harm Residents Affected - Few	provided a timeline of events, a summary of an interview with resident 10 dated 3/6/26, a staff sign in-sheet and in-service documentation, and the completed staff skill checks. The timeline stated the in-service was held on 3/10/26. The in-service covered the following topics: Why Proper Sling Removal Is Important, When to Remove the Sling, Steps for Proper Sling Removal, and Safety Reminders. It should be noted that the recertification survey was conducted from 4/19/26 through 4/27/26. On 4/29/26, the facility provided a Performance Improvement Project (PIP). The PIP documented that the Skin tear was treated and dressed, provider contacted for further orders and an audit was performed and identified 4 residents at risk of being affected d/t (due to) use of the hoyer lift was completed on 3/6/26. The Measures/Systemic Changes listed in the PIP were: providing education to clinical staff on the proper removal of the Hoyer sling to prevent skin injury and obtaining observation competencies from all CNAs to demonstrate removal competence. The PIP documented that these measures were completed on 3/6/26. The PIP's monitoring plan included CNA coordinator will perform randomized observation audits 3 times a week for 12 weeks to ensure continued competency of hoyer sling removal. The projected completion date was 6/10/26. The Hoyer Sling Removal/Observation Audits 3/16/26 through 4/26/26 were provided.

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	04/27/2026

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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, for 2 of 40 sampled residents, the facility did not ensure that pain management was provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Specifically, a resident's pain medications were decreased after admission and no appointment was made after the resident requested an appointment with the pain clinic. This example will be cited at a harm level. In addition, another resident's pain to her thumb knuckles was not addressed. Resident identifiers: 4 and 8. Findings included: 1. Resident 8 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included stage 4 pressure ulcers, paraplegia, osteomyelitis, spastic hemiplegia and injury of root of cervical spine. On 4/19/26 at 3:27 PM, an interview was conducted with resident 8. Resident 8 stated he was in a lot of pain and when he was admitted the house physician decreased his pain medication. Resident 8 stated he requested to be sent to a pain clinic because his pain medications were decreased when he was admitted . Resident 8 stated he did not have a phone to call his medical providers. Resident 8 stated he asked for telehealth with the pain clinic but that was never scheduled and they finally scheduled him for a pain clinic appointment that he had been asking for since October when he was admitted . Resident 8 was observed to groan when moving. A Nurse Practitioner (NP) note dated 11/4/25 at 2:39 PM revealed, [Resident 8] is a [AGE] year old male presenting for hisotry [sic] and physical. He has a history of neuralgia and neuritis, depression and anxiety, paraplegia, and osteomyelitis. Today he is complaining that his baclofen should be 60 mg [milligrams] 4 times daily. Supervising physician does not want to give that dose currently and I am referring to her for dosing. He is currently at 30 mg 4 times daily which is a total of 120 mg daily. He is actively in discomfort and has asked to see a pain management clinic. No other concerns at this time. Plan: . Continue medications as ordered . Monitor for any change in condition .f/u [follow up] appointments as ordered.A physician's admission note dated 10/31/25 at 11:57 AM revealed, .ROS [review of systems]: quadriplegia, wounds, chronic pain, muscle spasms, depression, anxiety, nausea . Plan: .4. Chronic pain/opioid dependence - will continue current meds 5. Muscle spasms - he says he cannot get a baclofen pump while he has wounds .A care plan initiated on 2/23/26 revealed resident 8 had potential for altercation in health maintenance related to his medical diagnoses. One of the goals was that resident 8 would have symptoms managed for comfort through the review date. Interventions included to monitor for increased pain and notify physician/nurse. A physician's note dated 3/2/26 at 11:00 AM revealed, . ROS : paralysis of LE [lower extremity], wounds, chronic pain, muscle spasms, . 4. Chronic pain/opioid dependence - will continue current meds. He wants more opioids. Staff do not feel this is indicated. Will refer to a pain clinic 5. Muscle spasms - he says he cannot get a baclofen pump while he has wounds.A physician office visit or referral to physician form dated 3/4/26 revealed Botox injection. There were no other notes on the form. A physician's note dated 4/3/26 at 11:49 AM revealed, [Resident 8] continues to report having pain. Nursing staff report his pain appears well controlled. He wants to go to a pain clinic and also wants to see [Name of physician removed] PM&R [Physical Medicine and Rehabilitation].a/p [assessment and plan] 1. Chronic pain - has been referred to pain clinic 2. Spinal cord injury - will refer to [name of physician] Resident 8's Medication Administration record for April 2026 revealed resident complained of pain higher than 6 twenty-one times. A pain scale was 0 for no pain and 10 for excruciating pain. On 4/22/26 at 11:01 AM, an interview was conducted with the Director of Nursing (DON). The DON stated resident 8 had gone to a spasticity clinic and provided the form from 3/4/26. On 4/22/26 at 2:23 PM, a follow up interview was conducted with the DON and Regional Nurse Consultant (RNC). The RNC stated when resident 8 was admitted , the physician was not comfortable with the amount of pain medication he was taking. The RNC stated they were not sure when resident 8 was referred to the pain clinic. The RNC stated resident 8 might have had an (continued on next page)

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	04/27/2026

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 0697 Level of Harm - Actual harm Residents Affected - Few	appointment at the pain clinic but was hospitalized or something. The DON stated the former ADON [Assistant Director of Nursing] knew about resident 8's pain clinic appointments but there was nothing documented. The DON stated there was no documentation that the pain clinic appointment was scheduled after admission. The DON stated prior to admission resident 8 was being seen at a pain clinic. The facility provided a timeline regarding resident 8's pain. On 11/12/25, the physician contacted his rehab physician regarding baclofen and it was concluded it would not be a safe thing to do with his wounds. On 11/25/25, a muscle relaxer was ordered for pain management and on 12/30/25 Baclofen was increased. Resident 8 did not bring up the pain clinic until February 2026, which was when a referral was put in but there was no documentation of when the pain clinic appointment was made. 2. Resident 4 was admitted to the facility on [DATE] and was re-admitted on [DATE] with diagnoses which included benign neoplasm of cerebral meninges, altered mental status, dementia, bipolar disorder, generalized anxiety disorder, post-traumatic stress disorder and acquired absence of left leg below knee. On 4/19/26 at 10:06 AM, an interview was conducted with resident 4. Resident 4 stated that she had pain in both thumbs and it caused her to lay awake all night. Resident 4's thumbs were observed to be red colored on both knuckles. Resident 4's physician orders revealed the following:a. Gabapentin Oral Tablet, Give 200 milligrams (mg) by mouth two times a day for phantom limb pain. The order was initiated on 3/27/24. b. Tylenol Tablet (Acetaminophen), Give 650 mg by mouth every 6 hours as needed (PRN) for pain. Not to exceed 3 grams in 24 hours. The order was initiated on 2/11/23. c. Monitor pain level every shift using (0-10 or FLACC [Face, Legs, Activity, Cry, and Consolability] scale). Acceptable pain level: 6. Document ALL interventions being utilized for pain management: 0) No intervention indicated d/t [due to] no pain 1) Scheduled pain medication 2) PRN [as needed] pain medication 3) PRN pain medication offered and refused 4) Repositioning 5) Rest 6) Ice/Heat 7) Other (specify in progress notes) 8) Resident refused all non-pharmacological interventions. The order was initiated on 1/12/24. Resident 4's April 2026 Medication Administration Record (MAR) documented Pain scores of 10 out of 10 on 4/7/26, 4/15/26, and 4/19/26 during the day shift (6:00 AM - 6:00 PM). The FLACC scores were documented as a 1 on 4/7/26, a 2 on 4/15/26, and a 0 on 4/19/26. The MAR documented that the interventions provided on all three dates were 1) Scheduled pain medication, 4) Repositioning, and 5) Rest. On 4/15/26 at 8:53 AM, the Tylenol administration note documented that the resident requested the medication. On 4/15/26 at 9:00 AM, the Tylenol progress note documented that the administration was effective and the follow up pain score was 3/10. It should be noted that the follow-up pain assessment was conducted 7 minutes after the medication was administered. On 4/7/26, the pain evaluation documented that resident 4 had occasional pain in the past 5 days and it occasionally impacted the resident's sleep and day-to-day activities. Resident 4 rated the worst pain over the last 5 days was a 6/10 and described it as moderate. Resident 4 described the pain as phantom limb pain of the left below the knee amputation. Resident 4 reported an acceptable level of pain was a 3/10. The resident reported that Tylenol, rest, repositioning, distraction and activities helped alleviate the pain. Resident 4 had a care plan focus area for altered comfort related to generalized pain initiated on 6/23/22. Interventions included to inform if pain medication was effective or monitor for signs and symptoms of effectiveness, monitor pain level using a numerical scale or FLACC scale, and that resident 4 was able to state what increased or alleviated her pain. On 4/27/26 at 9:10 AM, an interview was conducted with Licensed Practical Nurse (LPN) 2. LPN 2 stated that resident 4 sometimes had complaints of pain and had Tylenol and Gabapentin available. LPN 2 stated that for any reports of 10/10 pain levels she would try non-pharmacological interventions first such as listening to music as a distraction. LPN 2 stated that she would also inform resident 4 that she had Tylenol available. LPN 2 stated that resident 4's mood was hit and miss and she suffered from hallucinations and delusions. LPN 2 stated that resident 4 would often scoff when the Tylenol was offered for pain management. LPN 2 stated that the PRN pain note would document if the pain medication was offered or refused and you should be able to see if the treatment was provided. LPN 2 stated that for reports of 10/10 (continued on next page)

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	04/27/2026

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 0697 Level of Harm - Actual harm Residents Affected - Few	pain an intervention should be documented as provided or refused. LPN 2 stated that if resident 4 refused the Tylenol it should be documented as a #3 for offered and refused PRN pain medication. LPN 2 stated that #3 should have been documented on 4/7/26 and 4/19/26 if the Tylenol was refused for the pain levels of 10/10. On 4/27/26 at 9:51 AM, an interview was conducted with the Director of Nursing (DON) and the Regional Nurse Consultant (RNC). The DON stated that staff should do a FLACC score along with a numerical pain score when evaluating a resident's pain. The DON stated that staff would provide non-pharmacological interventions for pain management such as redirection and repositioning. The CRN stated that staff reported that redirection worked with resident 4's reports of 10/10 pain. The CRN stated that resident 4 did not understand her pain with her cognitive issues and if non-pharmacological interventions did not work staff would administer PRN pain medication. The CRN stated that on 4/7/26 and 4/19/26 they did not have documentation that the PRN Tylenol was administered or documentation of the effectiveness of the non-pharmacological interventions. The CRN stated that staff should take into consideration what resident 4 reported her pain was along with her cognitive decline and her ability to interpret her pain. The CRN stated staff should determine resident 4's source of the pain, what other circumstances might be contributing to the pain, and if they can resolve it at the moment. The CRN stated that maybe other things contributed to the 10/10 pain score and the staff were able to resolve it at the moment. The CRN stated that the nurses got used to the baseline of the resident and maybe they did not document what was going on fully. The facility Pain Management Policy documented that the facility would Recognize when the resident is experiencing pain and identify circumstances when the pain can be anticipated. The policy further stated that facility staff should observe for nonverbal indicators of pain such as: a. Change in gait (e.g. limping), skin color, vital signs (e.g. increased heart rate, respirations, and/or blood pressure), perspirationb. Loss of function or inability to perform activities of daily living (ADLs) (e.g. rubbing a specific location of the body, or guarding a limb or other body parts)c. Fidgeting, increased or recurring restlessnessd. Facial expressions (e.g. grimacing, frowning, fright, or clenching of the jaw)e. Behaviors such as: resisting care, distressed pacing, irritability, depressed mood, or decreased participation in usual physical and/or social activitiesf. Difficulty eating or loss of appetiteg. Weight lossh. Difficulty sleeping (insomnia)i. Negative vocalizations (e.g. groaning, crying, whimpering, or screaming)j. Decline in activity levelk. Skin conditions.The policy documented that non-pharmacological interventions included: a. Environmental comfort measures (e.g., adjusting room temperature, smoothing linens, comfortable seating, assistive devices or pressure redistributing mattress and positioning)b. Loosening any constrictive bandage, clothing or devicec. Elevating or supporting limbs (e.g., using a pillow or folded blanket)d. Physical modalities (e.g., cold compress, warm shower/bath, massage, turning and repositioning)e. Exercises to address stiffness and prevent contractures as well as restorative nursing programs to maintain joint mobilityf. Cognitive/behavioral interventions (e.g., music, relaxation techniques, activities, diversions, spiritual and comfort support, teaching the resident coping techniques and education about pain). The policy documented that pharmacological interventions should be specific to each resident who had pain or the potential for pain. The facility should Evaluate the resident's medical condition, current medication regimen, cause and severity of the pain and course of illness to determine the most appropriate analgesic therapy for pain. The policy was last updated in 2025.

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	04/27/2026

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 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 did not store, prepare, distribute and serve food in accordance with professional standards for food service safety. Specifically, the facility dish machine was not reaching the required temperature, dirty dishes were loaded from the clean side, gloves were not changed between touching dirty dishes and then clean, there were foods in the refrigerator that had been in there longer than 7 days and there were soiled areas in the kitchen. Findings include: 1. On 4/19/26 at 8:26 AM, an observation was made of the facility kitchen. The following was observed: a. There were 2 sanitizer buckets. Dietary Aide (DA) 1 stated she had changed the sanitizers 15 minutes prior. DA 1 was observed to use chlorine sanitizer testing strips. The white strips did not change color. DA 1 stated she did not know what color the strip should change to. DA 1 stated she used a sanitizer from the 3 compartment sink. An observation was made of the sanitizer and it was labeled Quaternary [Quat] sanitizer. b. [NAME] 1 was observed to place an omelet directly on the trayline counter and then pick it up and put it on the tray on top of other omelets. [NAME] 1 was observed to serve the omelet. c. The drink refrigerator was observed and there were 2 cups of milk with no date. d. The dry storage was observed. There was a brown substance on the pipes on the ceiling. The floor was observed to have a black substance on it. e. The walk in refrigerator was observed. There were 2 large tubes of ground meat dated 4/11/26, a ziplock back of brown gravy dated 4/12/26, 2 chicken drum sticks dated 4/12/26, sliced bologna dated 4/14/26 and 4 cups of fruit with no dates on them. f. The floor in the kitchen had black and brown substances around the outside walls, around the electrical outlet on the floor, and the legs of equipment. g. The dish machine was observed. The washing temperature was 90 degrees Fahrenheit. The rinse temperature was 110 degrees Fahrenheit. The April 2026 dish machine temperature log had the first date of 4/17/26. There were no temperatures written for 4/17/26 and for 4/18/26 there was no dinner temperature recorded and no temperatures recorded for 4/19/26. The log revealed the washing temperature needed to be above 120 Fahrenheit and rinse temperature needed to be above 75 degrees Fahrenheit with the sanitizer above 50 parts per million. 2. On 4/22/26 at 1:20 PM, there was a follow up kitchen tour conducted. The following was observed: a. The floor was soiled with a black substance around the outside walls, equipment legs, and around the electrical box on the floor. b. DA 2 was observed to test the sanitizer solution in a red bucket. DA 2 stated it was changed out every 1 to 2 hours. DA was observed to use the quaternary solution test strips. The strip was observed to change from orange to green. DA 2 stated he honestly dontt know what that means when asked what the colors meant. DA 2 stated he did not test it every time he made the solution. c. There was a mop bucket with black water in it next to where the clean dishes were removed from the dish machine. d. The dish machine log was filled in for all meals from 4/17/26 though 4/22/26 breakfast. The dish machine was observed: [Note: All temperatures were in degrees Fahrenheit.] i. At 1:30 PM, the washing temperature was less than 110. The rinse temperature was 119. A large pan was washed and put away by DA 3. ii. At 1:32 PM, DA 3 was observed to use gloved hands to pull out clean dishes from the dishwasher, use the same gloves to put dirty dishes into the dishmachine, and then use the same gloves to put away clean bases and heating pellets. iii. At 1:35 PM, the washing temperature was 100 and rinse temperature was 110. An interview was immediately conducted with [NAME] 2. [NAME] 2 stated the dish machine needed to be at 120 for the washing and rinsing cycles. [NAME] 2 stated if the temperature was not above 120 then she turned off all the sinks and ran the dish machine continuously until it was above 120. iv. At 1:37 PM, the washing temperature was 110 and the rinse temperature was 120. v. At 1:39 PM, DA 3 was observed to use a gloved hand to touch dirty dishes and then used the same gloved hands to put away a clean pan from the above cycle. DA 3 was then observed to put a washing machine tray on the clean side and push it into the dishmachine with the same gloved hands. vi. At 1:40 PM, the washing temperature was 105 and the rinse temperature was (continued on next page)

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	04/27/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	119. DA 3 was observed to put a basket with dirty dishes on the clean side of the dishmachine and push it into the dishmachine. vii. At 1:42 PM, the washing temperature was 110 and the rinse temperature was 119. On 4/22/26 at 1:44 PM, an interview was conducted with DA 3. DA 3 stated she was provided training on washing dishes, preparing meals, and knowing where everything was. DA 3 stated she was trained to make sure all dishes were scrubbed and the temperature of the dishmachine was above 120. DA 3 stated if the dish machine did not reach 120, then she needed to keep using it until the temperature was above 120. DA 3 stated she was not trained on how to load or unload the dishes. DA 3 stated she was trained to change her gloves when she changed tasks. On 4/22/26 at 1:47 PM, an interview was conducted with the Dietary Manager (DM). The DM stated all dishes needed to be put in the 3 compartment sink since the dishmachine was not reaching the required temperature. The DM stated the dish machine reached the required temperature during breakfast dishes. The DM stated the wash and rinse cycles both needed to be higher than 120 degrees Fahrenheit. The DM stated she did not know why the dishmachine temperature log was not filled out on 4/17/26 when observed on 4/19/26. The DM stated there was a dishmachine log for 4/1/26 though 4/16/26 which was on her desk. The DM provided the dishmachine log from 4/1/26 through 4/15/26. On 4/1/26 at lunch, the temperature was 50 for the wash, 50 for the rinse and 30 for the chlorine sanitizer. The DM stated the floors should be mopped nightly and the pipe with the dried substance in the dry storage should be cleaned. The DM stated staff should know that the sanitizer buckets used Quats sanitizer and it should be between 50 to 150 Parts Per Million.

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	04/27/2026

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 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, for 12 of 40 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 palatable or attractive, and there were resident council minutes and grievances with complaints of food quality. Resident identifiers: 1, 8, 10, 33, 50, 52, 54, 63, 66, 76, 78 and 92. Findings included: Resident interviews 1. On 4/19/26 at 9:48 AM, an interview was conducted with resident 10, who stated the food and coffee were usually served cold. Additionally, Resident 10 stated the food tasted awful. 2. On 4/19/26 at 12:44ˆPM, an interview was conducted with resident 33, who stated he was unable to chew the meat served because it was too tough. 3. On 4/19/26 at 10:43 AM, an interview was conducted with resident 63. Resident 63 stated Oh God, you had to ask when asked about food quality. Resident 63 stated I skip, honestly indicating he skipped meals. Resident 63 stated the cooks were bad and most of the time his food was either under cooked or over cooked with no seasoning. Resident 63 stated the food was tasteless. Resident 63 stated if there was seasoning, then he would start eating it again. Resident 63 stated They are cooking like shit. Resident 63 stated the country fried steak tasted like spam. 4. On 4/19/26 at 11:19 AM, an interview was conducted with resident 92. Resident 92 stated the food had not been good. Resident 92 stated he was served 2 overcooked hotdogs on a plate with no condiments, no bun and no side dishes. Resident 92 stated portions were too small for a person his size. 5. On 4/19/26 at 11:36 AM, an interview was conducted with resident 78. Resident 78 stated the food was terrible and she was always having to fill out alternative menus. Resident 78 stated she needed gluten-free food and was not served gluten-free. Resident 78 stated she used her $45 per month on gluten free food. 6. On 4/19/26 at 11:40 AM, an interview was conducted with resident 66. Resident 66 stated the food was terrible and she was always filling out alternative menus. 7. On 4/19/26 at 3:43 PM, an interview was conducted with resident 52. Resident 52 stated the food was really obnoxious sometimes. 8. On 4/19/26 at 3:24 PM, an interview was conducted with resident 8. Resident 8 stated the food was just terrible. Resident 8 stated he thought there were problems with paying cooks and having to work in a tiny kitchen to serve 80 residents. Resident 8 stated he received 2 slices of bread with a slice of cheese that was not melted and 4 bites of tomato soup. Resident 8 stated he was on a high protein diet for wound healing and that was not enough food. 9. On 4/19/26 at 2:39 PM, an interview was conducted with resident 1. Resident 1 stated that the kitchen did not follow her food preferences. Resident 1 stated that she was not supposed to eat potatoes and the only vegetable she could tolerate was corn. Resident 1 stated that the kitchen kept giving her peas and carrots. Resident 1 stated that she was not supposed to eat fruit because she was a diabetic. Resident 1 stated that she could not eat some of the food because it did not taste good. Resident 1 stated that the kitchen staff did not listen and they should pay attention to the resident diets. 10. On 4/19/26 at 3:51 PM, resident 50 stated that the food at the facility was not good and they have had several cooks rotate through. Resident 50 stated that they served a lot of broccoli, salad, and black beans. 11. On 4/19/26 at 11:28 AM, resident 54 stated he did not eat much of the food because he did not like it and because of this he made his own food. Resident 54 stated that he wanted food that put weight on him. Resident 54 stated that since admission he had lost a lot of weight. Resident 54 stated that he gets too much chicken and fish and he did not like it. 12. On 4/19/26 at 10:47 AM, resident 76 stated that the kitchen had been struggling and they cannot keep staff in the kitchen. Resident 76 stated that there was a lot of food that he could not eat and the facility did not have enough options. Resident 76 stated that alternative food options were a salad and hot dogs. Resident 76 stated that they had a lot of fish at the facility and he could not eat fish. Resident 76 stated that he got chicken every day and he was getting sick of it. Resident 76 stated that the food was not served warm and they microwaved the chicken which made it rubbery. Test tray On 4/21/26 at 12:40 PM, the last tray was placed on the cart and a test tray was requested. At (continued on next page)

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	04/27/2026

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12:55 PM, the last tray was delivered in the 200 hallway. The test tray was observed to have a slice of pepperoni pizza, a thin slice of bread, and a white cake. The pizza was 142 degrees Fahrenheit. The pizza was tough to chew and unable to be cut. The garlic bread was very thin and crunchy like a cracker. The white cake tasted like white cake with coconut topping. The tray had all brown and white foods on it. There was no color. Resident Council Minutes A review of resident council meeting notes revealed the following: a. On 8/5/25, the notes documented that residents had concerns about meal tickets, specifically the likes/dislikes, not being read.c. On 9/2/25, the Facility Response/Solution to the meal ticket concerns addressed in the previous resident council was documented as much better. Additionally, the notes documented that residents had concerns about dislikes and that the Dietary Manager (DM) would be updated so those dislikes would be on the meal tickets.b. On 4/7/26, the residents had dietary concerns with cold coffee and food. On 4/22/26 at 2:02 PM, an interview was conducted with the Dietary Manager (DM). The DM stated when residents disliked the food, they usually came to her and she fixed the problem. The DM stated there was a lot of new staff in the kitchen because there was high DA [Dietary Aide] turnover. The DM stated residents could also fill out a grievance form regarding food quality. The DM stated food preferences were asked upon admission and in care conferences. The DM stated after admission the residents could come to the kitchen and let her know their preferences and she would relay them to the kitchen staff. The DM stated a new plate warmer was ordered but had not arrived. The DM stated they usually kept the warmers for the 200 hallway. On 4/22/26 at 4:34 PM, an interview was conducted with the Administrator (ADM). The ADM stated the facility had a pellet warmer system ordered. The ADM stated there should be enough pellet warmers for the full facility. The ADM stated he completed audits after the last complaint survey because food palatability was cited. The ADM stated he did not have anything horrible to eat on the test trays. The ADM stated he had been in a lot of skilled nursing facilities and the food was not 5 star food. Grievance Report Form On 5/31/25, the grievance form documented the concern as Resident stated that her bread/roll this morning for breakfast was too hard, and she asked a CNA she believed to be [name omitted] to get her a new one. She stated that he never followed up with her and that she didn't get a new roll. The grievance was confirmed. The corrective action was to encourage the resident to approach the Dietary Manager with concerns. On 7/17/25, the grievance form documented the concern as Resident stated that he continues to get meats he can't chew on his meal trays. Resident does not have any teeth and is unable to chew certain foods. The grievance was confirmed. The corrective action was that staff would check his tray before delivering to the resident. On 8/5/25, the grievance form documented the concern as Residents stated that they continue to receive items on their tray that they dislike. The grievance was confirmed. The corrective action was that Certified Nurse Assistants (CNAs) will double check meal tickets to ensure the residents are getting the right diet and dislikes aren't on the trays. On 9/26/25, the grievance form documented the concern as [Name omitted] stated that she received old lettuce and cucumbers in her salad last night and undercooked chicken a couple weeks ago that she sent back to be cooked longer but never got back. The grievance was confirmed. The corrective action was that the kitchen was to confirm that the food was cooked thoroughly and fresh produce will be utilized, not wilted. On 11/14/25, the grievance form documented the concern as He wants staff to let him know what the menu will be daily so he can choose alternatives if he doesn't like the meal. Also for CNAs to tell them whats on his plate before feeding him. The grievance was confirmed. The corrective action was that staff will take more time to read the menu and explain what was on his meal tray.

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	04/27/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 it was determined, for 1 of 40 sampled residents, that the facility did not maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Specifically, observations were made of cross-contamination and improper hand hygiene practices during wound care, and Enhanced Barrier Precautions (EBP) was not implemented during wound care. Additionally, multiple observations were made of resident drinks being delivered throughout the facility while uncovered during transport. Resident identifier: 76. Findings included: 1. Resident 76 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included type II diabetes mellitus, morbid obesity, peripheral vascular disease, lymphedema, and atopic dermatitis. On 4/19/26 at 10:41 AM, an interview was conducted with resident 76. Resident 76 stated he had cellulitis on the right leg and an infection on the heel of his foot. Resident 76 stated that he had wound care to the foot 3 times a week and had been receiving wound care as long as he had been at the facility. Resident 76 did not have a sign indicating EBP was required outside the resident's room.On 4/17/26, resident 76's wound orders documented, Wound Care to Bilateral posterior thighs; Clean with wound cleanser, apply small hydrogel sheet on the inferior RIGHT thigh. Apply large hydrogel sheet dressing on BILAT [bilateral] posterior thighs. Change on shower days and PRN [as needed] one time a day every Tue [Tuesday], Thu [Thursday], Sat [Saturday] for poor skin integrity.On 4/17/26, resident 76's wound care orders documented, Wound care- Wounds to bottom of RIGHT foot. Clean with NS or wound cleanser and pat dry ApplyAquaphor/urea to feet, apply collagen SHEET, cover with boarder [sic] sorbact foam, and wrap feet with kerlix. Change every other day and PRN (DO NOT USE COBAN, IT WRAPS TOO TIGHTLY) one time a day every other day. On 4/22/26 at 11:27 AM, an observation and concurrent interview was conducted with Licensed Practical Nurse (LPN) 3 and Assistant Director of Nursing (ADON) 3 during resident 76's wound care. Both staff entered the resident's room and neither donned a gown for the wound care. LPN 3 and ADON 3 donned gloves, but no observation of hand hygiene was made prior to glove application. Resident 76 stood from his motorized wheelchair and LPN 3 placed a chucks pad on the seat of the wheelchair and resident 76 returned to the seat. LPN 3 doffed and donned new gloves. No hand hygiene was performed. LPN 3 stated that the dressing on the right foot was a Kerralite cool dressing. ADON 3 placed normal saline onto a package of 4x4 gauze pads. ADON 3 removed resident 76's sock on the right foot and pulled back the tubigrip. ADON 3 stated that there was not an old dressing present due to the resident having just showered. ADON 3 did not doff the dirty gloves, perform hand hygiene and don new gloves. ADON 3 cleaned the wound bed on the right foot with the normal saline soaked gauze. ADON 3 cleaned the wound bed from the outside inward and then back outwards in a back and forth motion, crossing over the center of the wound bed multiple times. ADON 3 doffed her dirty gloves and donned new gloves. ADON 3 stated that she needed to wash her hands prior to the application of new gloves but LPN 3 stated that she did not need to wash her hands as she was still clean. ADON 3 applied the Kerralite cool dressing over the top of the plantar wound. ADON 3 pulled the tubigrip down over the dressing and the sock was reapplied. ADON 3 did not label and date the new dressing. Resident 76 stated that the other wound was located on his bare butt. Resident 76 stood up from the wheelchair so that LPN 3 could have access to the wound. LPN 3 stated that the wound was to be cleansed with normal saline and then a hydrogel dressing was placed on the wound. LPN 3 opened 2 packages of 4x4 gauze and sprayed normal saline inside the package. LPN 3 opened one package of small hydrogel and 2 packages of the large hydrogel dressings. LPN 3 cleaned the wound bed wiping multiple times over the same site, in a back and forth motion. LPN 3 stated that the left inner thigh had one large wound and the right inner thigh had 2 smaller wounds. LPN 3 applied all packages of the hydrogel dressing to the wounds. The dressings (continued on next page)

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	04/27/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were not secured in place with a cover or adhesive. Resident 76's wound bed was not visualized as access was not possible due to limited space. The wound care was observed from the left lateral side of resident 76. LPN 3 then assisted resident 76 in pulling up his trousers. Resident 76 resumed his seat in the wheelchair.LPN 3 stated that he was going to wash his hands now. LPN 3 stated that with resident 76's wound care he was on EBP and they should have worn gowns. LPN 3 stated that gloves should be changed when moving to a new site, or touching any contaminated surface. LPN 3 stated that hand hygiene should be performed after each doffing and prior to donning of new gloves. LPN 3 stated that he did not want to exit the room to wash his hands during wound care because it would leave the dressing supplies open and exposed to possible contamination. LPN 3 stated that they could have brought Alcohol Based Hand Rub (ABHR) into the room to perform hand hygiene. LPN 3 stated that the process for cleaning a wound bed was to clean from the inside out, to reduce cross contamination and they should not go back and forth over the same site. ADON 3 stated that they did not label the foot dressing. On 4/22/26 at 11:49 AM, an interview was conducted with the Director of Nursing (DON), Regional Nurse Consultant (RNC), and ADON 4. The DON stated that EBP was for any resident that had intravenous (IV) access, a central line, a peripherally inserted central catheter (PICC) line, catheter care, wound care, chronic wounds, pressure ulcers, diabetic foot ulcers and unhealed surgical wounds. The DON stated that in EBP rooms staff should don gloves and gowns during resident care. The DON stated that during wound care they should don gloves at the beginning, after the first cleansing and before they start the next step of wound care. The DON stated that gloves should be doffed, hand hygiene performed and new gloves donned prior to cleansing the wound bed to prevent cross contamination. The ADON 4 stated that the new dressing should contain the date and the initials of the person performing the wound care. ADON 4 stated that staff should clean the wounds from the inside outward ensuring that they did not pass over the center of the wound bed again. ADON 4 stated the center of the wound bed was less contaminated and to reduce the risk of contamination staff should not pass over the same area more than once with the same cleansing wipe. On 4/22/26 at 1:47 PM, a follow-up interview was conducted with LPN 3. LPN 3 stated that he used Kerralite for the wound care because that was what the order was written for. LPN 3 stated that he called the wound nurse prior to the dressing change to clarify the order because they were previously using Kerralite. LPN 3 confirmed that the order was changed prior to resident 76's dressing change. Review of the facility policy for Enhanced Barrier Precautions (EBP) documented that it was an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDRO] that employs targeted gown and gloves use during high contact resident care activities. The policy documented that EBP were indicated for residents with any of the following: Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC lines, midline catheters) even if the resident is not known to be infected or colonized with a MDRO. (Peripheral IVs, continuous glucose monitors, insulin pumps, or ostomies without an associated indwelling medical device are not an indication for EBP.) The policy documented that high contact care activities included dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, and wound care. The policy was last revised in 2025.2. On 4/19/26 at 12:27 PM, an observation was made of Certified Nursing Assistant (CNA) 3. CNA 3 was observed to pour a cup of coffee into a mug in the dining room and transport it down the hallway uncovered to a resident room. 3. On 4/21/25 at 12:21 PM, an observation was made of staff transporting coffee from the 100 hallway dining room to room [ROOM NUMBER] uncovered. 4. On 4/19/26 at 12:19 PM, an observation was made of the lunch meal service in the 100 hallway. The meal cart was parked between rooms [ROOM NUMBERS]. Meals and drinks were served from this cart.At 12:21 PM, a cup of uncovered coffee was walked down the hallway and delivered to room [ROOM NUMBER]. At 12:24 PM, two cups of uncovered coffee were walked down the hall and delivered to room [ROOM NUMBER]. At 12:26 PM, (continued on next page)

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	04/27/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the meal cart was moved and parked between rooms [ROOM NUMBERS]. A cup of uncovered coffee was walked down the hall to room [ROOM NUMBER].At 12:29 PM, two cups of uncovered coffee were walked down the hall to room [ROOM NUMBER].

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	04/27/2026

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 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. Based on observation and interview the facility did not provide a safe, clean, comfortable, and homelike environment. Specifically, for 1 of 40 sampled residents, the facility did not clean a resident's window which was covered in dryer lint. Resident identifier: 63. Findings included: On 4/19/26 at 10:43 AM, an observation was made of resident 63's room. The window was covered in dryer lint. Resident 63 was interviewed. Resident 63 stated general cleaning was getting done but deep cleaning was not happening. Resident 63 stated the window needed to be wiped down. On 4/27/26 at 1:26 PM, an interview was conducted with Housekeeper (HK) 1.HK 1 stated that resident 63's room was deep cleaned last Monday (4/20/26). HK 1 stated that resident 63's window was located next to the dryer vent. HK 1 stated that she did not know when the last time the outside dryer vent was cleaned. HK 1 stated to ask the Housekeeping Manager when the window was cleaned last. On 4/27/26 at approximately 1:30 PM, an observation was made of resident 63's window. The window was completely obscured from view with little light penetrating and was covered in dryer lint on the outside. On 4/27/26 at 1:32 PM, an interview was conducted with the Housekeeping Manager (HM). The HM stated that the outside of the windows were not on the cleaning schedule and he did not know when they were last cleaned. The HM stated that resident 63's window was located near the dryer vent. The HM stated that he ordered replacement parts for the dryer vent last week that included a pipe and elbow attachment. The HM stated that once the new parts were installed the dryer lint would not hit the window anymore. The HM stated that cleaning of the outside windows was his responsibility but he had not cleaned them yet. The HM stated that he started his employment with the facility in November 2025 and the outside window cleaning was on the spring cleaning schedule. The HM stated that the dryer vent had been broken since December 2025. The HM stated that ordering the parts to fix the vent had not been done because it was not a priority.

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	04/27/2026

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined, for 1 of 40 residents sampled, that the facility did not ensure that prompt efforts to resolve grievances made by the residents were completed, tracked through the conclusion with a summary of the findings, and a statement as to whether the grievance was confirmed or not confirmed with any corrective action taken and the date it was completed. Specifically, the facility did not promptly resolve the grievance made by the resident and the grievance did not contain the investigation, summary of findings, or the conclusion of the investigation with dates. Resident identifier: 1. Findings included: Resident 1 was admitted to the facility on [DATE] with diagnoses which included type II diabetes mellitus, hypertension, anxiety disorder, major depressive disorder, and post-traumatic stress disorder. On 4/19/26 at 2:44 PM, an interview was conducted with resident 1. Resident 1 stated that she told the Resident Advocate (RA) that a Certified Nurse Assistant (CNA) let the door slam on her finger and it cut her finger causing it to bleed. Resident 1 stated that this incident occurred last week. Resident 1 stated that she filled out a grievance report with the RA. Resident 1 stated that the nursing staff put Neosporin and a bandage on the finger after the incident. Resident 1 stated that she did not know the name of the CNA but she worked the night shift. Resident 1 stated that no one should be treating the residents that way. On 4/10/26 resident 1's grievance documented the concerns as Resident Reported that the CNA [name omitted] (NOC) [night shift], does not hold the smoking door open for her and another resident. She stated that the CNA swings the door open and walks away. The form documented that upon initial interview an allegation of abuse or neglect was not identified. The grievance form did not have any documentation of the steps taken to investigate the grievance, a summary of the findings and conclusion, and if the grievance was confirmed or not. The form did not have a written decision date, resident signature, grievance officer signature, or Administrator signature. On 4/22/26 at 3:48 PM, an interview was conducted with the RA. The RA stated that when resident 1 went outside the CNA did not hold the door open for the resident. The RA stated that resident 1 reported that when she went to grab the door she had a small cut that reopened. The RA stated that she reported the incident to the Administrator (ADM) and Director of Nursing (DON). The RA stated that resident 1 presented the incident to her that when she went to stop the door from closing her cut reopened, but not that it was slammed on her. The RA stated that resident 1 mentioned that she felt like the CNA was in a hurry. The RA stated that resident 1 did not mention that she felt like the CNA was intentional in their actions and that the incident was directed at her purposefully. On 4/22/26 at 4:05 PM. an interview was conducted with the ADM, DON, and Regional Nurse Consultant (RNC). The ADM and DON stated that they were not informed of the incident with resident 1. The ADM stated that they would do an investigation and would check the camera footage. The DON stated that they would assess resident 1 for pain and injury. The ADM stated that they would obtain a statement from resident 1 and the employee. The RNC stated that there was nothing filled out on the back of the grievance form which indicated that it was still in progress. The ADM stated that if the form indicated that it was not an allegation of abuse then it should have been resolved within a couple of days of submission. The ADM stated that with this grievance being initiated on 4/10/26 it should have been resolved by now.

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	04/27/2026

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined, for 1 of 40 sampled residents, that the facility did not ensure that as needed (PRN) orders for psychotropic drugs were limited to 14 days unless the prescribing practitioner or attending physician documented a rationale in the resident's medical record and indicated the duration for the PRN order. Specifically, a resident's PRN order for Trazodone exceeded 14 days and the resident's medical record did not have a documented indication to extend the use with a duration for the order. Resident identifier: 8. Findings included Resident 8 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included paraplegia, post-traumatic stress disorder, depression, anxiety disorder, and insomnia. On 4/8/26, resident 8's physician ordered Trazodone HCL [hydrochloride] Tablet 150 milligram (mg) by mouth every 24 hours as needed for insomnia. The order was discontinued on 4/20/26, and reinstated on the same day. Resident 8's April Medication Administration Record (MAR) documented that the PRN order of Trazodone was administered on 4/10/26 at 1:39 AM, on 4/11/26 at 2:13 AM, 4/15/26 at 11:32 PM, on 4/18/26 at 12:37 AM on 4/19/26 at 1:56 AM and at 10:00 PM, on 4/20/26 at 10:08 PM, on 4/25/26 at 2:38 PM, and on 4/26/26 at 10:34 PM. It should be noted that on 4/19/26 resident 8 was administered the PRN dose of Trazodone 2 times within the 24 hour period and the order was for one PRN dose in 24 hours. On 11/24/25, resident 8's Psychotropic Medication Review did not have documentation for the on-going use of the PRN Trazodone medication. Resident 8's medical records were reviewed and no documentation could be found of the physician rationale to extend the PRN dose past 14 days with a duration of use. On 4/27/26 at 9:40 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that Trazodone was prescribed for insomnia. The DON stated that they had a psychotropic review that documented that a Gradual Dose Reduction (GDR) was contraindicated but did not document a rationale for the on-going PRN Trazodone order.

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	04/27/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that allegations of neglect, including events that caused reasonable suspicion of neglect, were reported immediately to the State Survey Agency (SSA). Specifically, for 1 of 40 sampled residents, the facility did not report a resident injury that occurred during a staff-assisted transfer with a mechanical lift to the SSA. Resident Identifier: 10. Findings included: Resident 10 was admitted to the facility on [DATE] with diagnoses which included unspecified fracture of right lower leg, paraplegia, cirrhosis of liver, rhabdomyolysis, and mild protein-calorie malnutrition. On 3/12/26 at 2:18 PM, an Event Note Template documented On 3/6/2026 as the Skilled nurse [SN] was completing a weekly skin assessment, skin breakdown was noted to resident buttocks. SN contacted nurse management and assessment of wound noted. Resident noted to have breakdown on right buttock, and shearing injury related to Hoyer sling being removed by CNA [Certified Nursing Assistant]. Contacted MD [Doctor of Medicine] and wound NP [Nurse Practitioner] for orders and to review interventions. On 04/22/26 at 4:52 PM, an interview was conducted with the administrator, who stated he was unsure if the incident was reported to the SSA. It should be noted that no documentation could be located to determine if the incident was reported to the SSA. [Cross refer to F689]

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	04/27/2026

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not provide an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. Specifically, for 1 of 40 sampled residents, a resident was not provided discharge planning. Resident identifier: 52. Findings include: Resident 52 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included chronic obstructive pulmonary disease, type 2 diabetes mellitus, cerebral infarction, schizophrenia, and history of transient ischemic attack. On 4/19/26 at 3:43 PM, an interview was conducted with resident 52. Resident 52 stated he would like to discharge to his own apartment or maybe an assisted living. Resident 52 stated the staff said he did not make enough money for the New Choice Waiver but he was on Medicaid. A Behavioral Complex Interdisciplinary Team Review on 4/17/26 at 1:09 PM revealed, . Resident has recommendations for specialized services or PASSR[Pre-admission Screening/Resident Review] Recommendations of Pt[patient] . discharge planning. There was no care plan in resident 52's medical record for discharge planning. On 4/22/26 at 3:48 PM, an interview was conducted with the Resident Advocate (RA). The RA stated resident 52 did not have a discharge plan and was going to need long term care (LTC). The RA stated resident 52 wanted to discharge to another LTC facility but they were full. The RA stated she had asked resident 52 if he wanted to send a referral to another facility and he said no. The RA stated resident 52 had brought up going to assisted living and discussed the new choice waiver with him but was not sure if he had an income. The RA stated she documented the discharge plan in the progress notes. The RA stated the Assistant Director of Nursing (ADON) completed discharge care plans.

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	04/27/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined, for 1 out of 40 residents, that the facility did not ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choice. Specifically, the facility did not provide a resident timely orders and treatments after they sustained a shearing wound. Resident identifier: 10 Findings included: Resident 10 was admitted to the facility on [DATE] with diagnoses which included unspecified fracture of right lower leg, paraplegia, cirrhosis of liver, rhabdomyolysis, and mild protein-calorie malnutrition. On 4/22/26 at 3:04 PM, an interview was conducted with resident 10, who stated that he had been cut on the buttocks during a Hoyer lift transfer by a new sling, which had sharper edges than his previous sling. Resident 10 stated that after the initial injury the sling was replaced. Resident 10 stated that the wound had been painful. On 3/6/26 at 6:30 PM, a Late Entry Progress Note documented Skilled nurse (SN) was completing a weekly skin assessment and noted skin breakdown to resident buttocks. SN contacted nurse management and assessment of wound noted. Resident noted to have breakdown on right buttock due to shearing injury related to Hoyer sling, Contacted MD (Medical Director) and wound NP (Nurse Practitioner) for orders and to review interventions. It should be noted that the creation date was 3/17/26 at 1:56 PM, 11 calendar days after the effective date. A review of Resident 10's medical record revealed that prior progress notes referencing the shearing injury were labeled as Late Entry and were created after 3/9/26. An order for was documented on 3/9/26, WOUND CARE --- Right buttocks --- Cleanse wound with NS [normal saline]. Pat dry. Apply zinc barrier cream layered with collagen powder. Cover with ABD [abdominal] pad to dress the wound. Apply zinc barrier cream to surrounding areas in proximity to the wound with compromised skin concerns. every night shift for Wound Care. It should be noted that the order was documented 3 calendar days after a late entry progress note documented that the shearing injury was discovered and assessed. A review of Resident 10's medical record revealed that the facility did not document any treatment orders or wound care provided for the resident prior to 3/9/26. On 4/22/26 at 3:26 PM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that because she was a new employee at the facility she was unfamiliar with the history of resident 10's wound. LPN 1 stated that a resident's Treatment Administration Record (TAR) contained any wound care orders and that staff documented all provided wound care in the TAR. On 4/22/26 at 4:52 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that she was informed on 3/6/26 of resident 10's wound by the Assistant Director of Nursing (ADON) 1, and they contacted resident 10's physician and Wound Care Provider (WCP) via phone to receive orders. The DON stated that it was determined the wound was a shearing injury sustained when a Hoyer sling was incorrectly removed from under the resident through interview, assessment, and discussions with the WCP. Furthermore, the DON stated the WCP gave verbal wound care orders and she was unsure why the orders were not entered into resident 10's medical record. The DON stated that when verbal orders are given, the nurse will enter them into the medical record and the provider will then electronically sign the orders. The DON stated that she knew that resident 10 was provided the wound care ordered that night due to the verbal communication she had with ADON 1, despite the order and cares not being documented in the TAR. On 4/27/26 at 11:45 AM, an additional interview was conducted with the DON, who stated that the nursing staff needed to document any events pertaining to each resident in the progress during their shift. The DON stated this incident should have been documented in the progress notes so other staff could refer to the incident if needed and so there was a paper trail and explanation of what happened. On 4/27/26 at 12:06 PM, a telephone interview was conducted with ADON 1, who stated that at the time the incident occurred it was reported to him by a floor nurse. ADON 1 stated he sent a picture of the wound to the wound care provider in order to receive orders. ADON 1 stated he remembered the (continued on next page)

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	04/27/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wound care orders were to use a zinc barrier, collagen powder and use an abdominal dressing to cover the wound but he was not sure if that was the exact order. ADON 1 stated that he, the DON, and the Corporate Resource Nurse all worked on the orders and put them into the medical record. ADON 1 stated he knew the floor nurse provided wound treatment on 3/6/26 and he was unsure why documentation showed that the order was not put into the medical record until 3/9/36. The order wasn't put in until the following Monday. ADON 1 stated that the weekend floor staff would not have received a notification to perform wound care if the order was not in the medical record, and subsequently they would not have known that resident 10 needed wound care. On 4/27/26 at 12:26 PM, a telephone interview was conducted with the WCP, who stated the facility called her in March 2026 to address resident 10's shearing injury. The WCP stated she did give an order for the wound, but she could not recall the specific details. The WCP stated that resident 10 refused to let her do an assessment when she was at the facility. A review of resident 10's medical record revealed that resident 10 refused the WCP's attempts to assess the shearing wound to his buttock on 3/13/26, 3/20/26, and on 3/27/26.

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	04/27/2026

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined, for 1 of 40 residents sampled, that the facility did not provide each resident the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Specifically, the facility did not demonstrate reasonable attempts to provide or arrange behavioral health services for a resident who was monitored for depressive statements and had tearfully expressed his lack of independence since suffering a stroke. Resident identifier: 54. Findings included: Resident 54 was admitted to the facility on [DATE] with diagnoses which included ischemic cardiomyopathy, unsteadiness on feet, muscle weakness, history of falling, need for assistance with personal care, asthma, chest pain, severe protein-calorie malnutrition, cachexia, contracture of left and right hand, takotsubo syndrome, and portal hypertension. On 4/19/26 at 11:39 AM, an interview was conducted with resident 54. Resident 54 became tearful multiple times during the conversation recounting his physical limitations since his stroke and lack of independence. Resident 54 stated that he did not currently have mental health services. On 9/2/25, resident 54 had a physician order for BEHAVIOR MONITORING: EXPRESSIONS OF SADNESS Q [every] SHIFT (Avoiding eye contact, drooping facial expression, withdrawing from social interaction, etc). On 9/2/25, resident 54 had a physician order for Observation: Behaviors - Observe every shift. If behavioral symptoms are present, attempt non-pharmacologic interventions. A) Relaxation/breathing techniques B) Music or TV of choice C) Offer food/fluids D) Assess for pain E) Offer toileting F) Offer activity or other distraction of choice G) Other (specify in note). Document effectiveness. every shift for Monitoring On 9/2/25, resident 54 had a physician order for Monitor Behaviors: DepressiveStatements Interventions: 1.ONE ON ONE; 2. ACTIVITY; 3. ADJUST ROOMTEMPERATURE; 4.BACK RUB; 5. CHANGE POSITION; 5.OFFER FLUIDS; 7.OFFER FOOD; 8. REDIRECT; 9.REMOVE RESIDENT FROM ENVIRONMENT; 10. TOILET; 11.OTHERS : sertraline every shift Monitoring. The order was discontinued on 3/22/26. The April 2026 Treatment Administration (TAR) documented 4 episodes of expressions of sadness. The Behavior monitoring documented daily non-pharmacological interventions for 36 out of 39 observations. The March 2026 TAR documented 3 episodes of expressions of sadness. The Depressive Statements monitoring documented 4 episodes for the month. The Behavior monitoring documented daily non-pharmacological interventions for 43 out of 62 observations. The February 2026 TAR documented zero episodes of expressions of sadness. The Depressive Statements monitoring documented zero episodes for the month. The Behavior monitoring documented daily non-pharmacological interventions for 43 out of 56 observations. The January 2026 TAR documented 2 episodes of expressions of sadness. The Depressive Statements monitoring documented 2 episodes for the month. The Behavior monitoring documented daily non-pharmacological interventions for 52 out of 62 observations. The December 2025 TAR documented zero episodes of expressions of sadness. The Depressive Statements monitoring documented 1 episode for the month. Behavior monitoring documented daily non-pharmacological interventions for 55 out of 62 observations. On 9/2/25, resident 54's baseline care plan did not have any documentation under social services or any identified psychosocial needs/problems. On 9/10/25, the Minimum Data Set (MDS) admission assessment documented that the Care Area Assessment (CAA) triggered Psychosocial Well-being and the triggering conditions were related to activity preferences. On 9/29/25, resident 54's Psychotropic Meeting Review documented Sertraline 50 milligram daily for Chest pain? Depression. The assessment documented 2 episodes of verbalization of sadness. Non-pharmacological interventions were Resident is encouraged to leave his room and interact with other residents through facility activities. Resident enjoys passing time watching TV and visiting with his roommate. Staff check in on resident and offer active listening often. Staff learn resident's preferences and accommodate them. The form documented that it was (continued on next page)

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	04/27/2026

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unclear why the resident was taking Sertraline and a gradual dose reduction (GDR) was initiated from 50 mg to 25 mg. On 10/11/25, resident 54's Psychosocial Assessment documented, He is alert and oriented x [times] 3. He scored a 12 on his most recent BIMS [Brief Interview for Mental Status] assessment, indicating moderate cognitive impairment. He is able to make his needs known verbally. He is able to understand and is able to be understood. The summary of adjustment to placement was He is adjusting well to placement and understands the situation and routine. He is pleasant and has been participating appropriately overall in the facility. The plan is for him to remain in the facility for long-term care. The behavioral concerns documented that his behavioral status was stable and he was cooperative and compliant with staff and care. The assessment documented that he was living in his truck prior to admission and was working with social services for his economic factors. Additional recommendations were Emotional support, redirection, reassurance, encouragement, validation, socialization and unconditional positive regard. Continue to monitor mood and behavior and notify MD [Medical Doctor] and DON [Director of Nursing] of any changes. Continue to monitor psychosocial well-being and notify LCSW [Licensed Clinical Social Worker] of any changes. On 10/27/25, resident 54's Psychotropic Meeting Review documented that he tolerated his GDR of Sertraline and they discontinued the medication. The form stated that they would monitor the resident again the following month. It should be noted that the resident did not have another Psychotropic review after the discontinuation of the Sertraline in October and further monitoring was not conducted. On 4/21/26 at 8:30 AM, an interview was conducted with the Resident Advocate (RA). The RA stated that resident 54 was seen by a local company who provided mental health services. The RA stated that she would verify how long resident 54 had been on services and how often he was seen by the provider. The RA stated when resident 54 was first admitted he was on an anti-depressant (Sertraline) and he did not have a diagnosis of depression. The RA stated that resident 54 had stated to the previous Assistant Director of Nursing (ADON) 2 that he was feeling depressed that was why he was referred for mental health services. The RA stated that resident 54 had a lot of family issues which caused him to feel lonely. The RA stated that resident 54 had expressed a loss of his independence but she had noticed an improvement in his mental health since he received his power wheelchair. It should be noted that no documentation could be found for mental health services for resident 54. On 4/21/26, the Regional Nurse Consultant (RNC) stated via email that resident 54 was not signed on with mental health services. Per our resident advocate, he has not expressed a desire to be on services. It should be noted that this was a contradiction to the RA's previous interview and statement that resident 54 had told ADON 2 that he was feeling depressed. On 4/22/26 at 8:14 AM, an interview was conducted with Licensed Practical Nurse (LPN) 3. LPN 3 stated that they monitored resident 54 for expressions of sadness because he had been depressed due to his family not coming around and also about losing weight. LPN 3 stated that resident 54 was not eating and that was why he was being monitored for depression. LPN 3 stated that resident 54's non-pharmacological interventions for depression were music, socializing during smoking breaks, watching old western movies, and encouraging him to attend activities. LPN 3 stated they documented how many episodes of sadness he had that shift and there should be a corresponding non-pharmacological intervention that was provided. On 4/22/26 at 8:22 AM, an interview was conducted with the Regional Nurse Consultant (RNC). The RNC stated that resident 54 did not need to request mental health services to be seen by a provider. The RNC stated that residents were asked during their initial care conference if they were interested in receiving behavioral health services. The RNC stated that the facility staff were good at picking up on resident mood changes and would initiate those services. The RNC stated that some residents refused behavioral health services and in those cases they would consistently ask them again. The RNC stated that staff should inform the Medical Doctor of any residents that needed mental health services and they also informed the RA so she could make the referral. The RNC stated that resident 54 had not voiced that he wanted mental health services and she was not sure if they had a documented refusal for those services. The RNC stated that resident 54 was admitted on Sertraline (continued on next page)

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	04/27/2026

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and there was nothing in the admission paperwork that indicated it was prescribed for depression. The RNC stated that the pharmacy said it could have been prescribed for chest pain and they were not sure what the indication for use was for the medication. The RNC stated that they had mental health services in the building 1-2 times a week and they would make a referral for resident 54 today.

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	04/27/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview it was determined that the facility did not store all drugs and biologicals in locked compartments and permit only authorized personnel to have access to the keys. Specifically, a medication cart was observed unlocked and unattended outside of resident rooms. Findings included: On 4/19/26 at 8:05 AM, an observation was made of the medication cart on the second floor between room [ROOM NUMBER] and 204. The cart was unlocked and unattended by nursing staff. On 4/19/26 at approximately 8:10 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 was observed exiting room [ROOM NUMBER]. RN 1 confirmed that he had left the medication cart unlocked and unattended. On 4/22/26 at 8:33 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that when staff walk away from the medication cart and no other staff were present it should be locked.

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	04/27/2026

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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined, for 1 of 40 residents sampled, that the facility did not obtain laboratory services to meet the needs of its residents. Specifically, the facility did not obtain a Basic Metabolic Panel (BMP) when ordered by the provider. Resident identifier: 8. Findings included: Resident 8 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included paraplegia, osteomyelitis, anemia, post-traumatic stress disorder, depression, anxiety disorder, and insomnia. On 4/15/26, resident 8's physician ordered a BMP to be obtained. No documentation could be found of the laboratory results in resident 8's medical records. On 4/27/26 at approximately 8:00 AM, the Director of Nursing (DON) was asked to provide the results for the BMP that was ordered on 4/15/26. On 4/27/26 at 8:40 AM, the Regional Nurse Consultant (RNC) communicated via email that they were still looking for the results of resident 8's BMP. On 4/27/26 at 9:40 AM, the DON stated that resident 8's BMP was never drawn and they could not find any evidence that the laboratory specimen was obtained. The DON stated that the phlebotomist felt like it was done but the laboratory could not find the results.

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	04/27/2026

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 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep complete, dated laboratory records in the resident's record. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined, for 1 out of 40 residents sampled, that the facility did not file in the resident's clinical record laboratory reports that were dated and contained the name and address of the testing laboratory. Specifically, a resident's urinalysis laboratory report was not located in the medical records. Resident identifier: 8. Findings included: Resident 8 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included paraplegia, osteomyelitis, anemia, post-traumatic stress disorder, depression, anxiety disorder, and insomnia. On 3/21/26, resident 8's physician ordered a urinalysis to be obtained. No documentation could be found of the laboratory results in resident 8's medical records. On 4/27/26 at approximately 8:00 AM, the Director of Nursing (DON) was asked to provide the results for the urinalysis that was ordered on 3/21/26. On 4/27/26 at 8:40 AM, the Regional Nurse Consultant (RNC) provided via email the laboratory results for the urinalysis. On 4/27/26 at 9:40 AM, the DON stated that resident 8's urinalysis results were obtained from the laboratory. The RNC stated that they had a copy from the laboratory at one point because it was sent to the provider, but she was not sure why it did not make it into resident 8's medical records.

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	04/27/2026

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 0779 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep signed and dated reports of x-rays and other diagnostic services in the residents record. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined, for 1 out of 40 sampled residents, that the facility did not file in the resident's clinical record signed and dated reports of radiologic and other diagnostic services. Specifically, the resident's chest x-ray report was not located in the medical records. Resident identifier: 6. Findings included: Resident 6 was admitted on [DATE] and re-admitted on [DATE] with diagnoses that included contracture right and left hand, dysphagia, hypothyroidism, dementia, atrial-fibrillation, pain, hypertension, chronic pain, deformity of left lower leg, peripheral vascular disease, and idiopathic neuropathy. On 4/19/26, resident 6's medical records were reviewed. On 1/10/26 at 9:37 AM, resident 6's progress note documented, Resident has productive cough and crackles bilaterally, MD [Medical Doctor] notified and STAT [immediate] CXR [chest x-ray] ordered.No documentation of the chest x-ray was found in resident 6's medical records. On 4/22/26 at 9:49 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that they tried to obtain stat results within 24 hours of the order being initiated. The DON stated that the appropriate timeframe to scan the report into the resident's medical records would be within 24 hours of receipt of the document during business hours. The DON stated that was the goal, but it did not always happen. On 4/22/26 at 10:39 AM, DON stated that the results came in on Saturday [1/10/26] and the Medical Doctor (MD) reviewed it with the nurse. The DON stated that it was located in a group chat. The DON stated that she did not know why it was not included in resident 6's medical records. The DON stated that they needed to work on their weekend process.

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	04/27/2026

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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interview and record review it was determined the facility did not employ a full-time, designated person to serve as the director of food and nutrition services. Specifically, the facility did not have a qualified food service director. Findings included: On 4/22/26 at 1:20 PM, an interview was conducted with the Dietary Manager (DM). The DM stated she did not have a certification. The DM stated she had been the DM for 3 years. The DM stated the Registered Dietitian (RD) was at the facility weekly for the nutrition at risk meeting and was available by phone anytime. The DM stated she had registered for the course a few times but then staffing was low in the kitchen and she was pulled to work in the kitchen. On 4/22/26 at 4:05 PM, an interview was conducted with the Administrator. The Administrator stated that he did not know if the DM had a certification. The Administrator stated the RD worked 1 day a week at the facility. (Cross refer to F804 and F812)

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	04/27/2026

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 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, for 1 of 40 sampled residents, the facility did not arrange timely services for outside resources that met professional standards and principles that applied to professional providing services. Specifically, a resident was not scheduled for a pain clinic appointment when pain was identified and the resident requested. Additionally, resident records were not secured, left unattended, and visible to any passerby. Resident identifier: 8. Findings included: 1. Resident 8 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included stage 4 pressure ulcers, paraplegia, osteomyelitis, spastic hemiplegia and injury of root of cervical spine. On 4/19/26 at 3:27 PM, an interview was conducted with resident 8. Resident 8 stated he was in a lot of pain and when he was admitted the house physician decreased his pain medication. Resident 8 stated he requested to be sent to a pain clinic because his pain medications were decreased when he was admitted . Resident 8 stated he did not have a phone to call his medical providers. Resident 8 stated he asked for a telehealth appointment with the pain clinic but that was never scheduled and they finally scheduled him for a pain clinic appointment that he had been asking for since October when he was admitted . A Nurse Practitioner (NP) note dated 11/4/25 at 2:39 PM revealed, .Plan: . Continue medications as ordered . Monitor for any change in condition .f/u [follow up] appointments as ordered. A care plan initiated on 2/23/26 revealed resident 8 had potential for altercation in health maintenance related to his medical diagnoses. One of the goals was that resident 8 would have symptoms managed for comfort through the review date. Interventions included to monitor for increased pain and notify physician/nurse. A physician's note dated 3/2/26 at 11:00 AM revealed, . ROS [review of system]: paralysis of LE [lower extremity], wounds, chronic pain, muscle spasms, .4. Chronic pain/opioid dependence - will continue current meds. He wants more opioids. Staff do not feel this is indicated. Will refer to a pain clinic . A physician office visit or referral to physician form dated 3/4/26 revealed Botox injection. There were no other notes on the form. A physician's note dated 4/3/26 at 11:49 AM revealed, [Resident 8] continues to report having pain. Nursing staff report his pain appears well controlled. He wants to go to a pain clinic and also wants to see [Name of physician removed] PM&R [Physical Medicine and Rehabilitation].a/p [assessment and plan] 1. Chronic pain - has been referred to pain clinic 2. Spinal cord injury - will refer to [name of physician]. On 4/22/26 at 11:01 AM, an interview was conducted with the Director of Nursing (DON). The DON stated resident 8 had gone to a spasticity clinic and provided the form from 3/4/26. On 4/22/26 at 2:23 PM, a follow up interview was conducted with the DON and Regional Nurse Consultant (RNC). The DON stated when a resident needed an appointment outside of the facility, there was a physician's order for the referral. The RNC stated there was an insurance issue, so the facility had trouble making appointments. The RNC stated there should be a trail of documentation regarding when appointments were scheduled. The DON stated there was no documentation that the pain clinic appointment was scheduled after admission. The DON stated prior to admission resident 8 was being seen at a pain clinic. 2. On 4/19/26 at 8:05 AM, an observation was made of the medication cart on the second floor between rooms [ROOM NUMBERS]. The computer was unlocked and open to resident records. The cart contained the nurse's resident roster and report sheet with medical information that was viewable by passersby. On 4/19/26 at approximately 8:10 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 was observed exiting room [ROOM NUMBER]. RN 1 confirmed that he had left the computer open and unattended. On 4/22/26 at 8:33 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that when staff walk away from the medication cart the Medication Administration Record and nurse report sheet should not be visible when staff were not around. The DON stated that staff should always protect resident privacy.

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	04/27/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, for 1 of 40 sampled residents, the facility did not maintain medical records on each resident that were accurately documented. Specifically, a resident had an order for 12 tablets of an antidepressant when the physician ordered 1 tablet. Additionally, the medication cart had the computer open to resident records and left unattended and a nurse report sheet with resident medical information was visible. Resident identifier: 4. Findings included: 1. Resident 4 was admitted to the facility on [DATE] with diagnoses which included muscle weakness, altered mental status, dementia, bipolar and pulmonary hypertension. A physician's order dated 2/27/25 and discontinued 3/4/25 revealed Wellbutrin XL [extended-release] oral tablet extended release 24 hours 150 milligrams [MG]. The directions were to give 12 tablets by mouth one time a day for depressive symptoms. A nursing progress note dated 2/26/25 at 10:38 AM revealed, .I received new orders and reviewed them with the facility NP [Nurse Practitioner] d/c [discontinued] Namenda and start Wellbutrin XL 150 mg po [orally] daily due to increased depressive symptoms. On 4/21/26 at 10:02 AM, an interview was conducted with the Regional Nurse Consultant (RNC). The RNC stated the Wellbutrin XL should have been 1 tablet and not 12. The RNC stated resident 4 did not get 12 tablets per day. The RNC provided pharmacy orders that revealed resident 4 received 30 tablets before reordering 30 days later. 2. On 4/19/26 at 8:05 AM, an observation was made of the medication cart on the second floor between room [ROOM NUMBER] and 204. The computer on the cart was open to resident records. The cart contained the nurse report sheet with resident medical information that was visible to passerby. The cart was unattended by nursing staff. On 4/19/26 at approximately 8:10 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 was observed exiting room [ROOM NUMBER]. RN 1 confirmed that he had left the medication cart unattended with resident information visible. On 4/22/26 at 8:33 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that when staff walked away from the medication cart medical records should not be visible to protect resident privacy.