STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065267	A. Building B. Wing	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winding Trails Post Acute	2800 Palo Pkwy Boulder, CO 80301

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48458 Based on observations, record review and interviews, the facility failed to ensure the right to refuse treatment for one (#14) of three residents reviewed out of 25 sample residents. Specifically, the facility failed to ensure Resident #14 was not treated and administered medications against his wishes. Findings include: I. Facility policy The Residents Rights policy, revised December 2016, was provided by regional director of clinical services (RDCS) #1 on 5/9/24 at 1:14 p.m. It read in pertinent part, These rights include the right to exercise his or her rights without interference, coercion, discrimination or reprisal from the facility, be informed about his or her rights and responsibilities and be informed of, and participate in his or her care planning and treatment. The Administering Medications policy, revised April 2019, was provided by RDCS #1 on 5/9/24 at 1:14 p.m. It read in pertinent part, If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR (medication administration record) space provided for that drug and dose. II. Resident #14 A. Resident status Resident #14, age 77, was admitted on [DATE]. According to the May 2024 computerized physician orders (CPO), diagnoses included aphasia (inability to communicate effectively) following cerebral infarction (stroke), diabetes, pulmonary embolism (blood clot), paranoid personality disorder (mental illness with pattern of distrust and suspicion of others) and dementia. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 3/20/24 minimum data set (MDS) assessment revealed Resident #14 had short and long term memory problems according to staff interviews. He was independent with eating, oral and personal hygiene and required supervision with showering and dressing. B. Observation On 5/9/24 at 11:40 a.m., Resident #14 was observed walking in the hallway. He was dressed and well-groomed. Resident #14 was accompanied by a staff member (had one to one supervision). The resident was speaking, however his speech was difficult to understand. C. Record review The psychosocial/behavior care plan, revised 3/8/24, revealed a plan for medication as ordered, which specified may mix medications in resident's food as resident has increased paranoia and aggression when attempting to give in pill form. On 4/17/24 at 8:00 a.m. a physician order was initiated for Risperidone 4 milligrams (mg) by mouth one time a day for irritation. The order instructed to mix medication with Resident #14's meal. On 4/26/24 at 8:00 a.m.,a physician order was initiated for Sertraline 50 mg, oral concentrate (liquid), one time per day for depression. The order was discontinued on 5/3/24. On 4/27/24 at 8:00 a.m. a physician order was initiated for Lamictal 25 mg oral solution (liquid), one time per day for 14 days, for post traumatic stress disorder (PTSD). The order was discontinued on 5/3/24 at 10:51 a.m. On 4/28/24 at 1:37 p.m. the primary care physician (PCP) note revealed Resident #14 was taking medications mixed into his hot chocolate. On 4/30/24 at 10:31 a.m. a nursing note revealed Resident #14 refused medication. The note documented the nurse tried two different times mixing the medication with his drink. The resident got suspicious and did not accept the drink containing the medications. On 5/1/24 at 12:30 p.m. a psychiatric progress note revealed the nursing staff told the physician that the resident may be catching on to medication-masking and had refused several doses. It was recommended to consider switching to flavorless Risperidone oral solution. On 5/1/24 at 5:19 p.m. the PCP note revealed Resident #14 was taking his medications in hot chocolate until 4/28/24. The resident was now refusing. He was not taking any of his medications for days and was very irritable. The note documented that the staff felt that the resident could taste the Lamictal and that was why he was refusing his medications and was now eating less. On 5/6/24 a certified nurse aide (CNA) note documented for the 6:00 a.m. to 6:00 p.m. shift revealed Resident #14 did not eat breakfast or lunch. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A review of Resident #14's meal intake record from 4/10/24 to 5/8/24 revealed he refused to eat or ate less than 50% of meals on 4/28/24, 4/29/24, 4/30/24, 5/1/24, 5/4/24 and 5/6/24. Prior to 4/28/24, Resident #14 ate more than 50% of breakfast and lunch 90% of the time during the 4/10/24 to 5/8/24 period D. Interviews The detective from the police department (DPD) was interviewed on 5/9/24 at 10:28 a.m. The DPD said he received a report the facility had forced Resident #14 to take medications by putting it into his food, possibly a chocolate shake, for the previous two weeks. The DPD said he was told the facility had contacted a mental health worker for assistance with alternate placement. He said the mental health worker reported the facility had reported hiding a prescribed medication, Risperidone, in Resident #14's food. Licensed practical nurse (LPN) #1 was interviewed on 5/9/24 at 11:54 a.m. LPN #1 said Resident #14 loved mocha coffee and enjoyed making the drink. She said the nursing staff put his medications in his drink to get him to accept the medications. LPN #1 said Resident #14 did not like pills in his mouth or handed to him and often refused medications. She said the licensed nurses had been giving medications to Resident #14 in his drink for about a month. LPN #1 said nurses spoke to the doctor about giving medications in his drink and it seemed to work. The director of nursing (DON) was interviewed on 5/9/24 at 12:55 p.m. The DON said nursing staff were crushing medication and putting it into Resident #14's hot chocolate without his knowledge. She said Resident #14 did not notice the medication was in the drink until the addition of the Lamictal and Sertraline medications were added. The DON said the new medications had an aftertaste and Resident #14 would no longer take them. She said Resident #14 began wanting to make his drink himself as he did not trust the staff and knew staff were hiding his medications in his drink. The DON said she knew staff were not supposed to disguise or mask medications and residents should always be informed what medications were being administered to them. The contract nurse consultant (CNC) was interviewed on 5/9/24 at 1:30 p.m. The CNC said she realized the facility was not to mask or disguise medications per the regulation. She said the guardian consented to hiding the medication in the resident's drink. The CNC said the team developed a plan to administer the medication without Resident #14's knowledge in order to minimize risk of harm to himself and others. The nursing home administrator (NHA) was interviewed on 5/9/24 at 2:47 p.m. The NHA said he was aware that staff were masking medications from Resident #14 and did not tell Resident #14 he was receiving the medications. He said the process of disguising the medication was care planned and Resident #14's guardian was aware. He said the resident had a right to refuse medication. Resident #14's representative was interviewed on 5/10/24 at 9:40 a.m. The representative said the facility had spoken with him about Resident #14's medications and they were hiding Resident #14's medications in his beverages. He said he did consent to the administration of medications without Resident #14's knowledge. He said the facility did not say anything to him about Resident #14's right to refuse administration of medications.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41172 Based on record review and interviews, the facility failed to ensure four (#18, #7, #3 and #15) out of four residents reviewed out of 38 sample residents were protected from resident to resident physical abuse by Resident #6 and Resident #14. Resident #6 admitted on [DATE] with a history of aggression. Between 1/17/24 and 1/18/24, Resident #6 was involved in at least three altercations with Residents #18, #7 and #3. The altercation with Resident #3 resulted in Resident #3 being transferred to the hospital for head trauma where he received twelve staples to his head. The facility was aware Resident #6 was wandering into other residents' rooms but failed to implement a plan to monitor the resident and redirect her from other residents. Additionally, the facility failed to implement a plan to prevent physical abuse to Resident #15, by Resident #14 who had known aggressive behavior. Findings include: I. Facility policy The Abuse and Neglect policy, revised March 2018, was received from the regional director of clinical services (RDCS) #1 on 3/7/24 at 10:55 a.m. The policy documented in pertinent part, Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. The nurse will assess the individual and document related findings. The nurse will report findings to the physician. The staff, with the physician's input as needed, will investigate alleged abuse and neglect to clarify what happened and identify possible causes. The facility management and staff will institute measures to address the needs of residents and minimize the possibility of abuse and neglect. The management and staff, with physician support, will address situations of suspected or identified abuse and report them in a timely manner to appropriate agencies, consistent with applicable laws and regulations. The medical director will advise facility management and staff about ways to ensure that basic medical, functional, and psychosocial needs are being met and that potentially preventable or treatable conditions affecting function and quality of life are addressed appropriately. The physician will advise the facility and help review and address abuse and neglect issues as part of the quality assurance process. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	II. Resident to resident physical abuse by Resident #6 to Resident #18 A. Incident on 1/17/24 On 1/17/24 at 11:20 a.m., the nursing progress notes for Resident #6 documented Resident #18 was sitting in his room calmly when Resident #6 repeatedly went into Resident #18's room. Resident #18 asked her to stop coming into his room. When Resident #18 was not looking, Resident #6 took his cane. Resident #18 yelled for the nurse. When the nurse went into the room Resident #18 was pulling Resident #6's hair. The residents were separated, and the facility had decided to move Resident #6's room for safety concerns. Resident #6 was encouraged to socialize with residents in common areas and not in resident rooms. On 1/17/24 at 11:34 a.m. the nursing progress notes for Resident #6 documented Resident #18 was sitting in his room and calm. Resident #6 repeatedly went in Resident #18's room even though the nurse asked her not to. Resident #6 took Resident #18's cane. When the nurse arrived Resident #18 was pulling Resident #6's hair. Resident #6 said she was punched. The NHA recovered Resident #18's cane. There were no injuries noted for either resident and Resident #6 agreed to a room move for safety concerns. On 1/17/24 at 4:57 p.m. a Change of Condition Evaluation documented Resident #6 was involved in a physical and verbal altercation. The evaluation documented Resident #6 was verbally and physically aggressive. The 1/17/24 facility investigation was received from the nursing home administrator (NHA) on 3/4/24 at 10:00 a.m. The investigation documented the Resident #6 and Resident #18 were immediately separated and there were no injuries to either resident. The investigation file contained a follow up statement from Resident #18 on 1/18/24 stating he was doing better and no longer upset. The investigation contained two resident interviews. One resident said they had heard about residents fighting on 1/17/24 and one resident said another resident had tried to punch her wheelchair and she had to tell him to stop. -There were no further resident interviews and no staff interviews found in the facility's investigation file. -The investigation documented that no agencies were notified such as the police, ombudsman or State Agency (cross reference F609 for failure to report an alleged violation). B. Resident #6 1. Resident status Resident #6, less than age 65, was admitted on [DATE] and discharged to the hospital on 1/18/24. According to the January 2024 computerized physician orders (CPO), diagnoses included traumatic brain injury (TBI), alcohol abuse, bulimia nervosa (eating disorder), encephalopathy (alteration in brain function or structure), borderline personality and major depression with severe psychotic symptoms. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	According to the 1/12/24 minimum data set (MDS) assessment, the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 13 out of 15. She was independent with personal hygiene, toileting, dressing, bed mobility, transfers and ambulation. The assessment documented the resident had symptoms of feeling down, hopeless, trouble concentrating with little pleasure in doing things. The assessment documented the resident did not wander but had a wander prevention device. 2. Record review A Preadmission Screening and Resident Review (PASRR) Level II Notice of Determination (NOD) for Mental Illness (MI), dated 12/18/24, documented Resident #6 had an open legal case for felony menacing and Resident #6's representative reported Resident #6 had been exhibiting aggressive behavior. The PASRR Level II was in the facility medical record for Resident #6 and had a printed date in the corner of 1/12/24. Resident #6's behavior care plan, initiated 1/15/24, documented Resident #6 wandered into other resident rooms and took or touched their belongings. The goal was the resident would accept supportive strategies and demonstrate adequate control of emotions which would not result in injury to self or others. Interventions included, administer medications as ordered, document behavior, encourage resident to verbalize feelings, establish rapport, maintain a calm, slow, understandable approach, notify the physician, responsible party of aggression and abusive behavior, observe and document changes in behavior, including frequency of occurrence and potential triggers, observe for clinical factors influencing behavioral indicators, observe resident's mood and response to medication, referred for psychiatry services -The care plan did not have interventions to address the resident's known behavior of wandering into other resident rooms and taking their belongings. C. Resident #18 1. Resident status Resident #18, less than age 65, was admitted on [DATE]. According to the February 2024 CPO, diagnoses included schizoaffective disorder, major depression, personality disorder, post traumatic stress disorder (PTSD) and traumatic brain injury (TBI). According to the 1/12/24 MDS assessment, the resident had moderate cognitive impairment with a BIMS score of 12 out of 15. He was independent with personal hygiene, toileting, dressing, bed mobility, transfers and ambulation. D. Staff interviews The NHA and the director of nursing (DON) were interviewed on 3/5/24 at 10:23 a.m. The NHA said she remembered Resident #6 took Resident #18's cane. The NHA said Resident #6 did take Resident #18's cane and the NHA found it and returned it to Resident #18. The NHA said Resident #18 then pulled Resident #6's hair. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The NHA said there were no further interviews of residents because the residents on that unit could not tell staff what was going on. She said the facility had to look for non verbal things. -However, the NHA could not describe what non verbal things were looked for. The NHA said she did not notify the police because she did not have time to. She said she would notify them. The NHA said she notified the ombudsman after the second incident (see below). The NHA said Resident #6 agreed to a room move. She moved to a room on the 300 hall. III. Resident to resident physical abuse by Resident #6 to Resident #7 A. Interviews regarding the incident on 1/17/24 A frequent visitor (FV) was interviewed on 3/4/24 at 2:38 p.m. The FV said she had several serious complaints regarding the facility. She said she was told Resident #6 placed a blanket around Resident #7's face. She said Resident #7 had been unable to move to protect herself. The FV said Resident #6 was then moved to a new hall where she assaulted Resident #3, resulting in 12 stitches to his face and his entire face was black and blue (see below). The FV reported that residents and staff were feeling unsafe and afraid to report facility issues such as abuse. The FV said the staff were told not to report the abuse by the DON and that she would handle it. The FV said she called the police as well as other resident family members and reported the incidents. The FV further said staff were told not to speak to the State Agency by the NHA or there would be consequences. A restorative nurse aide (RNA) was interviewed on 3/6/24 at 1:00 p.m. He said he was present the day Resident #6 assaulted Resident #7. He could not remember the exact day it occurred. He said he remembered staff were scrambling around to keep Resident #6 out of Resident #7's room because Resident #6 had turned off Resident #7's oxygen and was holding a blanket over her face. He said a staff member had to block the door so Resident #6 would not go back in the room with Resident #7. He said Resident #6 was moved to the 100 hall. The RNA said staff told him they were not to report the incident as abuse or that Resident #6 assaulted Resident #7, but to report it as a fall. The RNA said the facility had not provided any training in mental health or dementia (cross-reference F940 for failure to develop and implement an effective staff training program). The DON was interviewed again on 3/7/24 at 12:37 p.m. The DON said she was told Resident #6 was holding a blanket around Resident #7's face around 1/17/24. She said she was not at the facility that day. The DON said the NHA was at the facility and handled the situation. The DON said the NHA should have done an investigation but she did not (cross-reference F610 for failure to investigate an alleged violation). She said the nurse on duty witnessed the assault but she was an agency nurse and had not returned the DON's calls. The DON said she found out about the incident a few days after it occurred. The DON looked at her computer and said there was no assessment of Resident #7. She said Resident #6 was then moved to a new room and that was when she assaulted Resident #3 (see below). (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-The phone number and name of the agency nurse was requested and not received by the end of the survey on 3/7/24. -The NHA was unavailable for an interview. B. Resident #7 1. Resident status Resident #7, age 81, was admitted on [DATE] and readmitted on [DATE]. According to the March 2024 CPO, diagnoses include Parkinson's disease, major depression and dementia. According to the 1/30/24 MDS assessment, the resident had severe cognitive impairment with a BIMS score of four out of 15. She was totally dependent on staff for transfers and toileting. She required substantial to maximal staff assistance with bed mobility, dressing and personal hygiene. C. Record review -There were no progress notes in Resident #6 or Resident #7's medical record regarding the alleged assault. -There was no investigation and the alleged assault was not reported to the State Agency or the ombudsman (cross-reference F609 for failure to report an alleged violation and F610 for failure to investigate an alleged violation). IV. Resident to Resident physical abuse by Resident #6 to Resident #3 A. Incident on 1/18/24 On 1/18/24 at 10:28 a.m., an interdisciplinary team (IDT) note documented Resident #3 was pushed by another resident and obtained a laceration to the right eyebrow. -There were no recommendations by the IDT team. On 1/18/24 at 11:54 a.m., the nursing notes documented the nurse heard Resident #3 fighting with the same female resident he had been fighting with all day (Resident #6). The nurse observed arms flying at each other and Resident #3 lost his balance and fell hitting his face on the ground. There was a deep head wound from his glasses. Resident #3 complained of chin pain. On 1/18/24 at 3:38 p.m., the nurse note documented 911(emergency services) was called because the laceration to the right eyebrow area on Resident #3 was too large to steri-strip. On 1/18/24 at 3:52 p.m., a change of condition form documented that at approximately 11:30 a.m., Resident #3 was pushed by another female resident. The nurse documented she heard screams and ran to the hall to see Resident #6 push Resident #3. Resident #3 was bleeding from the right eyebrow and it was too large to apply steri-strips to. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 1/18/24 at 4:33 p.m., the nursing notes documented Resident #3 returned to the facility from the emergency room with 12 staples above his right eye. On 1/19/24 at 11:30 a.m., a provider note documented Resident #3 was involved in an altercation with another resident causing him to fall and strike his head. He presented to the ER (emergency room) with jaw pain and a large forehead laceration. On 1/20/24 at 11:30 a.m., the nursing notes documented Resident #3 continued with discoloration to his face after an altercation with another resident. The other resident had since been removed from the facility. On 1/21/24 at 3:53 a.m., the nursing notes documented Resident #3 continued with sutures to his head and bruising to the right eye, forehead and chin. The 1/18/24 facility investigation was received from the NHA on 3/4/24 at 10:00 a.m. The investigation documented Resident #3 and Resident #6 were immediately separated and Resident #6 was sent to the ER for a psychiatric evaluation. A social services interview in the investigation file, dated 1/18/24, documented Resident #3 said Resident #6 pushed him and was trying to do harm to me. A second social services note documented that, per staff, Resident #6 had been continuously wandering to Resident #3's unit. Staff had redirected her back to her own unit. Five resident interviews dated 1/19/24 did not document further abuse. -There were no further staff interviews. -There was no documentation the State Agency, police or ombudsman were notified. (cross-reference F609 for failure to report an alleged violation). B. Resident #3 1. Resident status Resident #3, age 71, was admitted on [DATE] and readmitted on [DATE]. According to the March 2024 CPO, diagnoses included intracranial hemorrhage (brain bleed), schizoaffective disorder and dementia. According to the 2/21/24 MDS assessment, the resident had severe cognitive impairment with a BIMS score of seven out of 15. He required supervision with dressing and transfers, and was independent with personal hygiene, bed mobility and toileting. C. Interviews (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Resident #8 was interviewed on 3/4/24 at 10:15 a.m. He said a female resident had assaulted a male resident and the police were not notified. He said the staff, a frequent visitor and a resident representative had called the police and there was now a detective involved. He provided a case number and the name of a detective. The NHA and the DON were interviewed together on 3/5/24 at 10:23 a.m. The DON said Resident #6 wandered into other resident rooms. She said she wandered into Resident #3's room and she pushed him. Resident #3 fell and cut his right eyebrow. Resident #6 was removed from the area. Resident #3 went to the ER and received seven or eight sutures. He had bruises on the right side of his face. The DON said Resident #6 was taken to the ER in the facility van for a psychiatric evaluation. The NHA said the resident wandered into other resident rooms. She wandered into the room of Resident #3. She pushed Resident #3 and he fell cutting his face. Resident #6 was then taken in the facility van to the hospital. However, Resident #6 jumped out of the facility van on the way to the hospital and was then taken by ambulance to the hospital and the facility discharged her. The NHA said the facility was not aware of the resident's history of aggression. She said the facility would be looking at referrals for new admissions more in depth. She said she would start approving residents with a history of aggression herself. The NHA said she did not know what the plan was to keep Resident #6 from wandering into other residents' rooms. She said the facility should have had a plan to monitor Resident #6 more closely. The social services director (SSD) was interviewed on 3/5/24 at 11:00 a.m. The SSD said he had not read Resident #6's PASRR Level II and was not familiar with her history. He said she was not here very long but shortly after she admitted she walked to the doorways of other residents and stared at them. This went on for a week. She had arguments with other residents, including Resident #18. The SSD did not recall exactly what happened with Resident #3. He said he remembered the residents were yelling at each other. He did not witness the altercation. He said he had noticed an increase in residents with mental health conditions coming into the facility since December 2023. The SSD said the facility had not provided any training in mental health, though he thought there should have been training. Licensed practical nurse (LPN) #4 was interviewed on 3/5/24 at 1:50 p.m. LPN #4 said she was told by other staff members Resident #6 assaulted Resident #3. She said the police had not been notified by the facility but a resident's family member had notified the police. LPN #4 said she was familiar with Resident #6. She said Resident #6 kept wandering into Resident #3's doorway. Resident #3 would tell her to leave, but Resident #6 would say I do not have to The RNA was interviewed on 3/6/24 at 1:00 p.m.The RNA said shortly after he heard a female yelling come on, come on, he went to the hall and saw Resident #3 on the floor with a gash in his head, bleeding all over. He said he was told by other staff member that Resident #6 had a rock in her hand and hit Resident #3 with it. V. Resident to resident physical abuse by Resident #14 to Resident #15 A. Incident on 1/12/24 (continued on next page)

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	065267	A. Building B. Wing	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winding Trails Post Acute	2800 Palo Pkwy Boulder, CO 80301

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The 1/12/24 facility investigation was received from the NHA on 3/4/24 at 10:00 a.m. A staff witness statement, dated 1/12/24, documented Resident #15 was pushing a chair and mistakenly hit Resident #14's foot. Resident #14 pushed Resident #15 who fell on the floor. Resident #14 then began hitting Resident #15 in the face before being pulled off of the resident. Three residents who witnessed the event were interviewed. The residents were asked: -How are you feeling? -How do you feel after the incident? -Would you like to speak to your family or friends? -Is there anything I can do to help you cope with the incident? -There were no resident interviews about abuse. -There were no staff interviews about abuse. -There was no documentation the State Agency or police were notified (cross-reference F609 for failure to report an alleged violation). B. Resident #14 1. Resident status Resident #14, age 77, was admitted on [DATE]. According to the March 2024 CPO, diagnoses included paranoid personality disorder, restlessness and agitation, cerebral infarction (stroke), aphasia (speech disorder) and vascular dementia. According to the 12/20/23 MDS assessment, the resident had severe cognitive impairment and could not complete the BIMS assessment. The staff assessment for mental status documented the resident had long and short term memory loss. He required supervision with dressing, transfer and toileting. He required setup assistance with personal hygiene and was independent with bed mobility. The assessment documented the resident had delusions and verbal behaviors directed towards others. The assessment documented the resident's behavior had gotten worse and disrupted care, the living environment and interfered with social interactions. 2. Record review On 1/10/24 at 3:00 p.m., the progress notes for Resident #14 documented he was hit with a chair on the right side. There were no injuries. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Resident #14's care plan, initiated 12/19/23, documented the resident was at risk for behavioral symptoms due to dementia and paranoid personality disorder. He had punched another resident at another facility. Interventions were to anticipate needs and meet promptly, document and record behavioral episodes, establish a rapport with the resident, maintain a calm, slow, understandable approach, manage environmental factors to optimize comfort, observe and document changes in behavior, including frequency of occurrence and potential triggers and observe resident's mood and response to medication. -There were no changes made to Resident #14's care plan after the altercation with Resident #15 on 1/10/24. C. Resident #15 1. Resident status Resident #15, age 85, was admitted on [DATE]. According to the February 2024 CPO, diagnoses included vascular dementia, anxiety and psychotic disorder with hallucinations According to the 12/4/23 MDS assessment, the resident had severe cognitive impairment and could not complete the BIMS assessment. The staff assessment for mental status documented the resident had long and short term memory loss. He was independent with bed mobility, and required supervision for dressing, transfers and toileting. He required set up assistance from staff with personal hygiene. The assessment documented he had physical and verbal behavior directed towards others. 2. Record review On 1/10/24 at 3:00 p.m., the nursing progress notes for Resident #15 documented Resident #15 was pushing furniture and accidentally ran into Resident #14 who then pushed Resident #15. Resident #14 continued to swat and hit Resident #15 with his hat. The residents were separated by staff. -There was no documentation about injuries. On 1/10/24 at 7:08 p.m., the nursing notes documented that Resident #15 had no injury. C. Staff interviews The NHA and DON were interviewed together on 3/25/24 at 10:23 a.m. The DON said Resident #15 was moving a chair around the nursing station. She said he used to be a janitor. He bumped into Resident #14 and Resident #14 pushed Resident #15 to the ground and began hitting him with his hat. The staff separated them. The DON said there were no injuries to either resident. The DON looked at both residents' electronic medical records(EMR) and said no changes were made to the residents' care plans following the incident. She said Resident #15 did have a history of aggression. She said he had post traumatic stress disorder from being assaulted by his wife. The NHA said she thought she notified the police and ombudsman around 1/12/24. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-However, there was no documentation provided to indicate the NHA had notified the ombudsman about the incident.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 48458 Based on observation, record review and interviews, the facility failed to develop and implement written policies and procedures that prohibit and prevent retaliation for abuse reporting. Specifically, the facility failed to: -Post a conspicuous notice of employee rights, including the right of staff to be free from retaliation for reporting abuse; and, -Include protection for employees against retaliation for reporting in its abuse policy. Findings include: I. Professional reference According to the Elder Justice Act notice, undated, retrieved online 3/11/24 from https://lms.healthcareacademy.com/courses/HCA_Annual/ElderJusticeAct1d/EJA_poster.pdf: The Elder Justice Act (the Act) is a federal law passed as part of the Patient Protection and Affordable Care Act. Its aim is to combat abuse, neglect and exploitation of elders by promoting the discovery of crimes against residents of long term care facilities. It does this by requiring that specific individuals report any reasonable suspicion of a crime against anyone who is a resident of, or is receiving care from, a long term care facility. A long term care facility may not retaliate against an employee for making a report, or for causing a report to be made. This means that a facility may not discharge, demote, suspend, threaten, harass, or deny a promotion or other employment-related benefit to an employee or in any other manner discriminate against an employee in the terms and conditions of employment because of lawful acts done the employee; or file a complaint or a report against a nurse or other employee with the appropriate State professional disciplinary agency because of lawful acts done by the nurse or employee. II. Observation The facility was observed on 3/7/24 at 11:43 a.m. for signage regarding employees' right to non-retaliation. This signage was not found in the facility. II. Record review The Abuse and Neglect policy, revised March 2018, was provided by the regional director of clinical services (RDCS) #1 on 3/7/24 at 10:55 a.m. -The policy did not address retaliation for reporting abuse or neglect. III. Staff interviews (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The director of nursing (DON) was interviewed on 3/7/24 at 12:37 p.m. The DON said she did not know where the notice was posted that indicated the facility would not retaliate against employees for reporting abuse. She said a notice against retaliation should have been posted. Certified nurse aide (CNA) #8 was interviewed on 3/7/24 at 3:00 p.m. CNA #8 said she had never seen signage that notified staff of their right to be free from retaliation for reporting abuse.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 41172 Based on staff interviews and record review, the facility failed to report alleged violations of potential abuse to the proper authority in accordance with State law for alleged violations involving eight (#4, #17, #6, #7, #3, #18, #14 and #15) of eight residents reviewed for allegations of abuse out of 38 sample residents. Specifically, the facility failed to: -Report an allegation of verbal abuse by Resident #4 to Resident #17 to the nursing home administrator (NHA), director of nursing (DON), local police or the State Agency; -Report an allegation of physical abuse by Resident #6 to Resident #7 and Resident #3; -Report an allegation of physical abuse between Resident #6 and Resident #18; and, -Report an allegation of physical abuse by Resident #14 to Resident #15. Findings include: I. Facility policy and procedure The Abuse and Neglect policy, revised March 2018, was received from the regional director of clinical services (RDCS) #1 on 3/7/24 at 10:55 a.m. The policy documented in pertinent part, Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish.The management and staff, with physician support, will address situations of suspected or identified abuse and report them in a timely manner to appropriate agencies, consistent with applicable laws and regulations. II. Verbal abuse by Resident #4 to Resident #17 A. Resident #4 1. Resident status Resident #4, [AGE] years old, was admitted on [DATE]. According to the March 2024 computerized physician orders (CPO), diagnoses included alcohol abuse. The 2/19/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. He was independent with all activities of daily living. 2. Record review (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Review of Resident #4's nursing progress notes revealed there was no documentation about any verbal altercations with Resident #17. B. Resident #17 1. Resident status Resident #17, age greater than 65, was admitted on [DATE]. According to the February 2024 CPO, diagnoses included septic right knee, lumbar abscess and chronic pain syndrome. According to the 2/19/24 MDS assessment, the resident had mild cognitive impairment with a BIMS score of 14 out of 15. She required substantial maximal assistance from staff with transfers, dressing, toileting and personal hygiene. She required moderate assistance from staff with bed mobility. 2. Resident interview Resident #17 was interviewed on 2/29/24 at 2:54 p.m. Resident #17 said a couple months ago she was talking to one of the nurses at the nurses station. She said they were talking loudly and laughing. She said Resident #4 came out of his room, rolling fast in his wheelchair. Resident #17 said Resident #4 came up to her at the desk and threatened to harm her and hit her. Resident #17 said Resident #4 smelled of alcohol and said something about harming her if she was rude to his favorite nurse. Resident #17 said Resident #4 drank alcohol in his room. She said she had seen him hide beer cans in his clothes and the beer cans were found in the residents' computer room at night. Resident #17 said maybe Resident #4 thought she and the nurse were arguing because they were talking loudly. Resident #17 said she tried to stay away from Resident #4 now. 3. Record review -Review of Resident #17's nursing progress notes revealed there was no documentation about any verbal altercations with Resident #4. C. Staff interviews The NHA was interviewed on 3/5/24 at 10:24 a.m. The NHA said the nurse had not reported to her or the DON the threats made by Resident #4 to Resident #17. She said the nurse should have reported the threats as verbal abuse. The NHA was interviewed again on 3/6/24 at 9:11 a.m. The NHA said the nurse said she was having a friendly conversation with Resident #17 and having fun. The nurse said Resident #4 came out of his room and said to Resident #17 If you do something to my friend, I am going to do something to you. The NHA said she did not ask Resident #17 if she was fearful of Resident #4. The NHA said Resident #17 said she just tried to stay away from Resident #4. III. Physical abuse by Resident #6 to Resident #7 A. Resident #6 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Resident status Resident #6, age less than 65, was admitted on [DATE] and discharged to the hospital on 1/18/24. According to the January 2024 CPO, diagnoses included traumatic brain injury (TBI), alcohol abuse, Bulimia Nervosa (eating disorder), encephalopathy (alteration in brain function or structure), borderline personality disorder and major depression with severe psychotic symptoms. According to the 1/12/24 MDS assessment, the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 13 out of 15. She was independent with personal hygiene, toileting, dressing, bed mobility, transfers, and ambulation. The assessment documented the resident had symptoms of feeling down, hopeless, trouble concentrating with little pleasure in doing things. The assessment documented the resident did not wander but had a wander prevention device. B. Resident #7 1. Resident status Resident #7, age 81, was admitted on [DATE] and readmitted on [DATE]. According to the March 2024 CPO, diagnoses included Parkinson's disease, major depression and dementia. According to the 1/30/24 minimum data set MDS assessment, the resident had severe cognitive impairment with a BIMS score of four out of 15. She was totally dependent on staff for transfers and toileting. She required substantial to maximal staff assistance with bed mobility, dressing, and personal hygiene. C. Staff interviews The DON was interviewed on 3/7/24 at 12:37 p.m. The DON said she was told Resident #6 was holding a blanket around Resident #7's face around 1/17/24. She said she was not at the facility that day. The DON said the NHA was at the facility and handled the situation. The DON said the NHA should have done an investigation and reported it to the police and the State Agency but she did not. She said the nurse on duty witnessed the assault, but she was an agency nurse and had not returned the DON's calls. The DON said she found out about the incident a few days after it occurred. -The NHA was unavailable for an interview on 3/7/24. D. Record review -There was no facility investigation provided for the incident (cross-reference F610 for failure to investigate abuse allegations) and no evidence the State Agency or police were notified of the allegation. IV. Physical abuse by Resident #6 to Resident #3 A. Resident #3 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Resident status Resident #3, age 71, was admitted on [DATE] and readmitted on [DATE]. According to the March 2024 CPO, diagnoses included intracranial hemorrhage (brain bleed), schizoaffective disorder and dementia. According to the 2/21/24 MDS assessment, the resident had severe cognitive impairment with a BIMS) score of seven out of 15. He required supervision with dressing and transfers, and was independent with personal hygiene, bed mobility and toileting. 2. Record review On 1/18/24 at 10:28 a.m., an interdisciplinary team (IDT) note documented Resident #3 was pushed by another resident and obtained a laceration to the right eyebrow. On 1/18/24 at 11:54 a.m., the nursing notes documented the nurse heard Resident #3 fighting with the same female resident he had been fighting with all day (Resident #6). The nurse observed arms flying at each other and Resident #3 lost his balance and fell hitting his face on the ground. There was a deep head wound from his glasses. Resident #3 complained of chin pain. B. Facility investigation The facility investigation of the incident was received from the NHA on 3/4/24 at 10:00 a.m. -The facility investigation did not contain documentation to indicate the State Agency and police were notified of the incident. V. Physical abuse between Resident #6 to Resident #18 A. Resident #18 Resident #18, age less than age 65, was admitted on [DATE]. According to the February 2024 CPO, diagnoses included schizoaffective disorder, major depression, personality disorder, post traumatic stress disorder (PTSD) and traumatic brain injury (TBI). According to the 1/12/24 MDS) assessment, the resident had moderate cognitive impairment with a BIMS score of 12 out of 15. He was independent with personal hygiene, toileting, dressing, bed mobility, transfers and ambulation. B. Record review On 1/17/24 at 11:20 a.m. the nursing progress notes for Resident #6 documented Resident #18 was sitting in his room calmly when Resident #6 repeatedly went into Resident #18's room. Resident #18 asked her to stop coming into his room. When Resident #18 was not looking, Resident #6 took his cane. Resident #18 yelled for the nurse. When the nurse went into the room Resident #18 was pulling Resident #6's hair. The residents were separated, and the facility had decided to move Resident #6's room for safety concerns. Resident #6 was encouraged to socialize with residents in common areas and not in resident rooms. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility investigation of the incident was received from the nursing home administrator on 3/4/24 at 10:00 a.m. -There was no documentation the State Agency or police were notified of the incident. VI. Physical abuse by Resident #14 to Resident #15 A. Resident #14 1. Resident status Resident #14, age 77, was admitted on [DATE]. According to the January 2024 CPO, diagnoses included paranoid personality disorder, restlessness and agitation, cerebral infarction (stroke), aphasia (speech disorder) and vascular dementia. According to the 12/20/23 MDS assessment, the resident had severe cognitive impairment and could not complete a BIMS. The staff assessment for mental status documented the resident had long and short term memory loss. He required supervision with dressing, transfer, and toileting. He required setup assistance with personal hygiene and was independent with bed mobility. The assessment documented the resident had delusions and verbal behaviors directed towards others. The assessment documented the resident's behavior had gotten worse and disrupted care, the living environment and interfered with social interactions. B. Resident #15 1. Resident status Resident #15, age 85, was admitted on [DATE]. According to the February 2024 CPO, diagnoses included vascular dementia, anxiety and psychotic disorder with hallucinations. According to the 12/4/23 MDS assessment, the resident had severe cognitive impairment and could not complete a BIMS. The staff assessment for mental status documented the resident had long and short term memory loss. He was independent with bed mobility, and required supervision for dressing, transfers and toileting. He required set up assistance from staff with personal hygiene. The assessment documented the resident had physical and verbal behavior directed towards others. C. Record review On 1/10/24 at 3:00 p.m., the nursing progress notes for Resident #15 documented Resident #15 was pushing furniture and accidentally ran into Resident #14 who then pushed Resident #15. Resident #14 continued to swat and hit Resident #15 with his hat. The residents were separated by staff. -There was no documentation about injuries. The facility investigation of the incident was received from the NHA on 3/4/24 at 10:00 a.m. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-There was no documentation the State Agency or police were notified of the incident. VII. Staff interview The NHA and the DON were interviewed on 3/5/24 at 10:23 a.m. The NHA said she did not recall if the abuse incidents involving Resident #4 and Resident #17, Resident #6 and Resident #7, Resident #6 and Resident #3, Resident #6 and Resident #18 or Resident #14 and Resident #15 were reported to the State Agency or the police. VIII. Additional record review The State Agency system was reviewed and there were no reports submitted by the facility for the abuse incidents involving Resident #4 and Resident #17, Resident #6 and Resident #7, Resident #6 and Resident #3, Resident #6 and Resident #18 or Resident #14 and Resident #15.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41172 Based on record review and interviews, the facility failed to ensure incidents of potential abuse were thoroughly investigated for three (#6, #18 and #7) of four residents out of 38 sample residents. Specifically, the facility failed to: -Ensure a known physical abuse incident between Resident #6 and Resident #18 was thoroughly investigated; and, -Ensure reports of physical abuse by Resident #6 to Resident #7 were followed up on and investigated. Findings include: I. Facility policy The Abuse and Neglect policy, revised March 2018, was received from the regional director of clinical services (RDCS) #1 on 3/7/24 at 10:55 a.m. The policy documented in pertinent part, Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. The nurse will assess the individual and document related findings. The nurse will report findings to the physician. The staff, with the physician's input as needed, will investigate alleged abuse and neglect to clarify what happened and identify possible causes. II. Physical abuse between Resident #6 and Resident #18 A. Resident #6 1. Resident status Resident #6, age less than 65, was admitted on [DATE] and discharged to the hospital on 1/18/24. According to the January 2024 computerized physician orders (CPO), diagnoses included traumatic brain injury (TBI), alcohol abuse, bulimia nervosa (an eating disorder), encephalopathy (alteration in brain function or structure), borderline personality disorder and major depression with severe psychotic symptoms. According to the 1/12/24 minimum data set (MDS) assessment, the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 13 out of 15. She was independent with personal hygiene, toileting, dressing, bed mobility, transfers and ambulation. The assessment documented the resident had symptoms of feeling down, hopeless, trouble concentrating with little pleasure in doing things. (continued on next page)

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	065267	A. Building B. Wing	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winding Trails Post Acute	2800 Palo Pkwy Boulder, CO 80301

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The assessment documented the resident did not wander but had a wander prevention device. B. Resident #18 1. Resident status Resident #18, less than age 65, was admitted on [DATE]. According to the February 2024 CPO, diagnoses included schizoaffective disorder, major depression, personality disorder, post traumatic stress disorder (PTSD) and traumatic brain injury (TBI). According to the 1/12/24 MDS assessment, the resident had moderate cognitive impairment with a BIMS score of 12 out of 15. He was independent with personal hygiene, toileting, dressing, bed mobility, transfers and ambulation. C. Record review On 1/17/24 at 11:20 a.m., the nursing progress notes for Resident #6 documented Resident #18 was sitting in his room calmly when Resident #6 repeatedly went into Resident #18's room. Resident #18 asked her to stop coming into his room. When Resident #18 was not looking, Resident #6 took his cane. Resident #18 yelled for the nurse. When the nurse went into the room Resident #18 was pulling Resident #6's hair. The residents were separated, and the facility had decided to move Resident #6's room for safety concerns. Resident #6 was encouraged to socialize with residents in common areas and not in resident rooms. On 1/17/24 at 11:34 a.m. the nursing progress notes for Resident #6 documented Resident #18 was sitting in his room and calm. Resident #6 repeatedly went in Resident #18's room even though the nurse asked her not to. Resident #6 took Resident #18's cane. When the nurse arrived Resident #18 was pulling Resident #6's hair. Resident #6 said she was punched. The nursing home administrator (NHA) recovered Resident #18's cane. There were no injuries noted for either resident and Resident #6 agreed to a room move for safety concerns. On 1/17/24 at 4:57 p.m. a Change of Condition Evaluation documented Resident #6 was involved in a physical and verbal altercation. The evaluation documented Resident #6 was verbally and physically aggressive. The 1/17/24 facility investigation was received from the nursing home administrator (NHA) on 3/4/24 at 10:00 a.m. The investigation documented Resident #6 and Resident #18 were immediately separated and there were no injuries to either resident. The investigation file contained a follow up statement from Resident #18 on 1/18/24 stating he was doing better and no longer upset. The investigation contained two resident interviews. One resident said they had heard about residents fighting on 1/17/24 and one resident said another resident had tried to punch her wheelchair and she had to tell him to stop. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-There were no further resident interviews and no staff interviews found in the facility's investigation file. D. Staff interview The NHA and the director of nursing (DON) on 3/5/24 at 10:23 a.m. The NHA said there were no further interviews of residents because the residents on that unit could not tell staff what was going on. She said the facility had to look for non verbal things. -However, the NHA could not describe what non verbal things were looked for. -The NHA had no explanation for the lack of staff interviews in the investigation. III. Physical abuse by Resident #6 to Resident #7 (cross-reference F600 for abuse) A. Resident #7 1. Resident status Resident #7, age 81, was admitted on [DATE] and readmitted on [DATE]. According to the March 2024 CPO, diagnoses included Parkinson's disease, major depression and dementia. According to the 1/30/24 minimum data set MDS assessment, the resident had severe cognitive impairment with a BIMS score of four out of 15. She was totally dependent on staff for transfers and toileting. She required substantial to maximal staff assistance with bed mobility, dressing, and personal hygiene. B. Record review -There were no progress notes in Resident #6 or Resident #7's medical records regarding the alleged assault. The facility investigation of the alleged incident was requested from the DON on 3/7/24 at 12:37 p.m. -The DON was unable to provide an investigation file for the incident between Resident #6 and Resident #7. C. Staff interviews The DON was interviewed on 3/7/24 at 12:37 p.m. The DON said she was told Resident #6 was holding a blanket around Resident #7's face around 1/17/24. She said she was not at the facility that day. The DON said the NHA was at the facility and handled the situation. The DON said the NHA should have done an investigation and reported it to the police and the State Agency (SA) but she did not. She said the nurse on duty witnessed the assault, but she was an agency nurse and had not returned the DON's calls. The DON said she found out about the incident a few days after it occurred. -The NHA was unavailable for an interview on 3/7/24.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 41172 Based on observations, interviews, and record review, the facility failed to provide an environment as free of accident hazards as possible and failed to ensure residents received adequate supervision and assistance devices to prevent accidents for nine (#1, #2, #3 #14, #15, #21, #33, #34 and #38) of 17 residents reviewed for accident hazards out of 38 sample residents. I. Facility failure to prevent elopement and implement a comprehensive and effective approach to prevent further elopement created a situation of immediate jeopardy for serious harm. Resident #1 and Resident #2 eloped from the facility together on 2/19/24 between 9:30 a.m. and 10:00 a.m. Both residents were assessed by the facility to be at risk for elopement and had orders to wear a wander-prevention device. The residents were found in a neighborhood two and a half blocks away from the facility when a good Samaritan called the police. Resident #1 had fallen and was transferred to the hospital with a broken hip. Resident #2 returned to the facility. She was not wearing a wander-prevention device as ordered. On 2/29/24, Resident #2 was observed. As on 2/19/24, and without facility knowledge, the resident was not wearing a wander-prevention device. Further observations revealed the front doors to the facility failed to alarm with the approach of a wander-prevention device and the door was open. The facility did not have a plan to monitor the doors 24 hours per day. Additionally, the facility failed to ensure that the wander-prevention devices worn by Resident #14, #15, and #21 were checked for function each shift, that Resident #3, assessed and care planned for a wander-prevention device, had orders for use of the device; and that the facility policy addressed the prevention of elopement. The facility's failure to prevent elopement and implement a systemic and effective approach to prevent further elopement created a situation of immediate jeopardy for serious harm. II. Facility failure to take steps to address other accident hazards. Observations, record review, and interview revealed the facility failed to: Timely complete smoking assessments; failed to provide assistive smoking devices; and failed to securely store chemicals and used razors. Findings include: ELOPEMENT I. Immediate jeopardy A. Findings of immediate jeopardy (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/19/24 at approximately 10:00 a.m., two residents, Resident #1 and Resident #2, with known exit-seeking wandering behaviors, left the facility together without the facility's knowledge. Both residents had physician orders for the use of a wander-prevention device. The residents left the building through the front door of the facility which was equipped with a wander-prevention system but did not lock or alarm. Resident #1 and Resident #2 were found by the police on 2/19/24 at approximately 10:15 a.m. in a neighborhood two and a half blocks away from the facility. Resident #1 had fallen and sustained a fractured hip. Resident #2 returned to the facility. Record review revealed Resident #2 was not wearing a wander-prevention device on the day of the elopement as ordered or when observed during the survey on 2/29/24 at 12:34 p.m. Record review further revealed three of the residents with orders for wander-prevention devices (Resident#14, #15, and #21) had no ongoing monitoring to ensure their devices were functioning properly. The facility's response following Residents #1 and #2's' elopement through the front door was to have the receptionist monitor the area during the day. However, the facility did not have a plan to monitor the front door when there was not a receptionist on duty. Further, on 2/29/24 at 9:00 a.m., there was no receptionist observed for several minutes at the front entrance. Staff reported the doors were locked after 5:00 p.m. There were mixed reports on how the doors could be opened after 5:00 p.m. The facility had not implemented a comprehensive and effective process to ensure the front entrance was not left unsecured or unattended to prevent additional resident elopements. The facility was located in the proximity of heavy road traffic, making further serious harm or serious injury likely. Furthermore, the facility was not checking the function of all of the wander prevention devices routinely. B. Facility notice of immediate jeopardy On 2/29/2024 at 2:22 p.m., the nursing home administrator (NHA) was informed that the facility's failure to prevent elopement and implement a comprehensive and effective approach to prevent further resident elopement created a situation of immediate jeopardy for serious harm. C. Temporary plan to keep residents safe On 2/29/24 at 5:40 p.m., the NHA provided a temporary plan to keep residents safe from elopement. The plan included that Resident #2 was placed on one-to-one supervision with a staff member at all times, and a staff person would be at the front desk 24 hours per day, seven days per week until the front door functioned properly - locking and alarming when in a closed position with the approach of a wander-prevention device and alarmed if a resident with a wander-prevention device approached and the door was in the open position. Residents with wander-prevention devices would all be checked for function each shift. D. Facility plan to remove immediate jeopardy The Plan to remove immediate jeopardy read: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Beginning on 2/29/24, the Elopement and wandering policy was reviewed/revised by the director of nursing (DON) or Designee to ensure the facility is following policy. The DON or designee educated staff beginning on 2/29/24 on the policy for Wandering, Elopement and Resident safety with a plan to complete 3/6/24. The DON or designee educated staff beginning 3/5/24 on a new Elopement prevention policy, with a plan to complete staff in-service on 3/6/24. Staff not educated, including agency staff, will be educated by the NHA or designee before their next shift. Resident #1 is discharged . Resident #2 was discharged from the facility and admitted to [another facility] on 3/1/24 due to [a] history of removing wander guard and elopement. Her son agreed, and she was transported to a new facility on 3/1/24. The NHA or Designee called the door company [that] services the wander guard system. They came out on 3/1/2024 to adjust doors. However, as of 3/5/24, doors continue to not consistently lock and alarm with a wander guard. On 3/5/24 the door company was contacted to return and further evaluate and repair the front door. Beginning on 2/29/24, 24 hours, seven day per week, a staff member has been stationed at the door until the door can be adjusted to decrease the time it takes the door to close once opened, ensure the door locks and alarms when a resident approaches with a wander guard, ensure the door alarms if the door was already open and a person with a wander guard approaches. The staff person will remain at the front desk 24 hours per day, seven days per week until the front door, alarms and locks as a resident with a wander guard approaches, and when the front door still alarms if open already and a resident with a wander guard approaches. The NHA will verify the door is working properly by checking the door with a wander-prevention device prior to discontinuing the front desk person monitoring the door. The door will alarm and lock when a resident with a wander-prevention device approaches. When the door is open, the door will alarm if a resident with a wander prevention device approaches. As of 2/29/24, the elopement management binder, which includes pictures of residents with elopement risks, will be available at the front desk. The person stationed at the door was educated on the elopement management binder by the NHA on 2/29/24. Plan: On 2/29/24, All residents were reevaluated for elopement risk utilizing the elopement risk assessment form or evaluation in electronic record. Residents found to be at risk of elopement were evaluated by the IDT (interdisciplinary team) to determine appropriate interventions. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Residents determined to require a wander guard have a consent, care plan, orders were updated to include placement of device monitoring every shift for function and placement completed 3/4/24. On 2/29/24, The DON or designee audited the elopement risk evaluations to match the care plans, completed on 3/4/24. On 2/29/24, the facility revised its pre-admission screening intake form to include a question about history and frequency of wandering and elopement by the Admissions Director. This will be an ongoing process and interventions will be put in place on admission as appropriate for wandering/elopement risk. Beginning on 2/29/24, The DON or designee will audit new admissions for elopement risk and ensure appropriate interventions are in place by the next business day. This will be ongoing. The licensed nurses will be educated beginning 3/5/24 to implement elopement interventions if a resident was assessed at risk for elopement on admission. The IDT will review the assessment the next business day for further intervention or continued risk. Beginning 2/29/24, new hires will receive education on wandering and prevention, wander guards, elopement procedure, and resident safety on day one of employment by the DON, Director of Social Services, or designee(s). On 3/5/24 the facility revised the Elopement policy to include prevention of elopement. Facility staff were educated on the new policy beginning 3/5/24. Staff who have not been educated will be educated prior to the start of their next shift. A Quality Assurance Performance Improvement (QAPI) Performance Improvement Project (PIP) was implemented to review and interpret all audit findings. All findings will be discussed at the monthly QAA meeting for at least three months or until the pattern of compliance is maintained. A QAPI meeting was completed on 3/1/24. The QAPI committee reviewed the elopement, policies and procedures and reviewed interventions that can be used for residents attempting to elope, including utilizing outdoor areas. E. Removal of immediate jeopardy The immediate jeopardy situation was removed on 3/7/24 at 2:50 p.m., based on the implementation of the actions set out in the plan to prevent elopements and to maintain resident safety. However, the deficient practice remained at a G level, isolated, actual harm. II. Facility policy on 2/29/24 when the survey began The Elopement policy, revised in December 2007, was received from the NHA on 2/29/24 at 10:00 a.m. The policy documented in pertinent part, Staff shall promptly report any resident who tries to leave the premises or is suspected of being missing to the Charge Nurse or (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Director of Nursing (DON). If an employee observes a resident leaving the premises, he or she should attempt to prevent the departure in a courteous manner, get help from other staff members in the immediate vicinity, instruct another staff member to inform the charge nurse or the DON that a resident left the premises. When a departing individual returns to the facility, the Director of Nursing Services or Charge Nurse shall examine the resident for injuries, notify the attending physician, and notify the resident's legal representative (sponsor) of the incident. The policy did not include any procedures to prevent resident elopement. III. Facility failure to prevent resident elopement and to implement a comprehensive and effective approach to prevent further elopements. Observations on 2/29/24 at 9:15 a.m. revealed the facility was located next to a main highway with heavy road traffic. A. Resident #1 1. Resident status Resident #1, age 85, was admitted on [DATE] and discharged to the hospital on 2/19/24 following an elopement, fall, and hip fracture on 2/19/24. The resident did not return to the facility. According to the February 2024 computerized physician orders (CPO), diagnoses included Alzheimer's dementia, anxiety, muscle weakness, and abnormal gait. The 1/10/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of two out of 15. He was independent with personal hygiene and required supervision with toileting, partial staff assistance with dressing, and supervision with transfers and ambulation. The assessment documented the resident did not wander and did not have a wander-prevention device. 2. Record review On 1/3/24, a wandering assessment documented the resident was at risk of wandering with a wander risk score of 30 due to being fully ambulatory, disorientated and confused, wandering aimlessly, voicing a desire to leave, and history of elopement attempts. A score of 10 or higher was a wandering risk. On 10/13/23, the resident had orders for a wanderguard (wander-prevention device) due to a lack of safety awareness. There were no orders to check the placement or function of the wander-prevention device. The elopement care plan initiated on 10/13/23 documented the resident was at risk of elopement due to elopement/exit-seeking related to altered cognitive status, dementia, exit-seeking behaviors, and forgetfulness. Interventions, dated 10/13/23, included allowing wandering in safe areas, attempting to refocus when exhibiting behavior, checking door alarms promptly to ensure safety, elopement bracelet at all times, and check placement every shift. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The progress notes were reviewed on 2/29/24 at 4:00 p.m. -On 2/19/24 at 2:03 p.m., the nursing progress notes documented the nurse spoke to the resident's son and told the resident's son the resident did have a wander-protection device on when he eloped from the facility that morning. On 2/19/24 at 3:21 p.m. the nursing notes documented the resident eloped from the facility that morning with another resident around 9:30 a.m. to 10:00 a.m. The resident was admitted to the hospital with a possible hip fracture after falling outside. B. Resident #2 1. Resident status Resident #2, age 74, was admitted on [DATE] and discharged on [DATE]. According to the February 2024 CPO, diagnoses included major depression and a history of delirium. The 1/10/24 MDS assessment revealed the resident had severe cognitive impairment with a BIMS score of six out of 15. She required set-up assistance with personal hygiene and toileting and required supervision with dressing and transfers. The assessment documented she did not wander and did not wear a wander-prevention device. 2. Record review On 1/3/24, a wandering assessment documented the resident was at risk of wandering with a wander risk score of 16 due to confusion, medications, and cognitive impairment. On 1/23/24, the resident had orders for a wander bracelet to the right wrist due to wandering and exit-seeking behaviors. Instructions were to check placement and function every shift. The elopement care plan initiated 1/3/24, documented the resident was at risk of elopement related to delirium and dementia. Wanderguard placed for safety. On 1/3/24, the interventions were to allow wandering in safe areas, approach in calm non threatening manner, attempt to refocus when exhibiting behavior, check door alarms to ensure safety, wander prevention device bracelet to right wrist, encourage expression of feelings, and redirection. On 1/23/24 a wander-prevention device was again added to the care plan. On 2/25/24, five days after the resident eloped, the care plan documented administer medications as ordered, assure identification band is in place, keep photograph in risk for elopement binder, assess for placement in specially designed therapeutic unit, monitor whereabouts frequently, reassure the family or significant other knows where they are. The progress notes were reviewed on 2/29/23 at 2:30 p.m. The nursing progress notes documented the following: -On 1/28/24 at 5:06 p.m. the progress notes documented the resident was very confused and exit-seeking all day. The resident was trying to open every door and looking for her car to go home. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-On 2/1/24 at 2:26 p.m., a social service note documented the resident occasionally exit seeks and wanders. On 2/19/24 at 1:24 p.m., a nursing progress note documented a new wander-prevention device was placed on the resident's right ankle. On 2/19/24 at 2:34 p.m. the nursing notes documented the resident eloped the building today around 9:30 a.m. to 10:00 a.m. The resident came back to the building around 11:00 a.m. The resident was missing her wander-prevention device from her right wrist. She had no injury. IV. Facility investigation A. Investigation file The NHA provided an investigation file of the 2/19/24 elopements on 2/29/24 at 10:00 a.m. The file contained the following: A timeline documented on 2/19/24 at 7:30 a.m., the residents (Resident #1 and Resident #2) got up at 7:30 a.m. They ate breakfast at 8:15 a.m. in the 400 hall dining room. At 9:00 a.m. the nurse administered medication. Between 9:15 a.m. and 9:30 a.m., certified nurse aide (CNA) #1 escorted the residents to the activity room for group activities. Between 10:00 a.m. and 10:13 a.m., the residents left the activity room and went walking in the neighborhood. At 10:15 a.m., a call was received from the police that they had two of the facility's residents. The residents were two and a half blocks away from the building. Two facility leadership members went to escort the residents back to the facility. One resident came back, and the other went to the emergency room . A separate timeline dated 2/29/24, signed by the director of nursing (DON) documented the DON arrived at the facility on 2/19/24 around 10:10 a.m. There was no receptionist at the desk. The business office manager (BOM) notified the DON the police had called and said they had found two of [the facility's] residents (Resident #1 and Resident #2). That was around 10:13 a.m. The DON went to the 400 hall where both residents resided to look for them. LPN (licensed practical nurse) #5 told the DON some residents had gone to activities. CNA #1 was sent to the activities area to look for Resident #1 and Resident #2. They were not there. CNA #1 said he had taken both residents to the activity area around 9:30 a.m. The two admissions office staff got in their car and went to the hospital. The admissions staff brought Resident #2 back to the facility, and Resident #1 had been admitted to the hospital. The police came to the facility and took a report. A document titled, Elopement Contributing Factors, undated, documented, no receptionist at the front desk during reception hours, residents left group activities without an escort, [wander-prevention] system did not prompt the door to lock down, the sensor on the [wander-prevention] system was too narrow. The residents had to get inches from the door before it secured. The facility had no security system which could have movement sensors to notify leaders. A witness statement from LPN #5, dated 2/20/24, documented that on 2/19/24, between 9:00 a.m. and 9:30 a.m., the residents were sitting in the dining room watching television. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A witness statement from CNA #1 documented she saw the residents around 9:00 a.m. to 9:30 a.m. a little after breakfast. The statement read that after breakfast, the CNA collected trays, took a resident to activities, and then returned to the floor. In the investigation file, attached to an in-service sign-in sheet, was a document titled, Tips for Elopement, dated 2/20/24. It documented, Involve the family in the prevention strategy by supervising residents during key risk times. Room placement for easy observation. React to statements such as I want to go home. Observe for aimless wandering, fear, or anxiety about the surroundings, involve the activities department in the prevention strategy; involve residents in small groups and activities that engage the resident's attention at key risk times. Consider the value of reality orientation (may not be appropriate for cognitively impaired residents). Review physical plants to be sure door alarms are working and that unauthorized areas are properly locked to prevent resident entry. Consider the use of a Chain of Custody'' for high-risk residents; develop a schedule for periodic checks on the resident. When the resident is involved in other activities or disciplines in the facility, such as dining and activities programs, the nursing assistant may give responsibility to that department for the periodic check, until the resident is returned to the assigned nursing assistant. Never assume everyone knows the resident is a wanderer; make it clear to dining room aides, new staff, and whoever is involved in the resident's care even for a short period of time. Consider the use of color-coded wristbands as an alert to staff. Consider the use of a personal alarm for the resident. Involve the resident in activity groups with small supervisory ratios; Avoid large group activities where supervision is minimal. An in-service form dated 2/20/24 documented all cognitively impaired residents should be escorted to and from activities and to alert nursing staff when residents are taken to activities and the dining room. A quality assurance and performance improvement plan (PIP) document dated 2/22/24 documented, on 2/19/24, All residents with [a wander-prevention device] will be identified. Residents with a [wander-prevention device] will have their [wander-prevention device] checked per orders, this education will be a return demonstration from the staff member that is checking the [wander-prevention device]. -Wander risk/Elopement risk assessments to be completed on all residents. Appropriate next steps to be taken including care plan updates, orders, notifications, consents. Attempts to ensure that there is facility identification for those that have [a wander-prevention device] will be done. -Education of all staff will be completed on the elopement policy and procedure. The elopement book will be kept up to date related to wandering or elopement assessment with a picture and a face sheet. Elopement drills will be completed monthly. Two-hour checks are encouraged for residents, and the [wander-prevention] system reviewed to ensure proper function on a routine basis. However, none of the tasks listed above had a person assigned or completion date. The columns for each of the items were blank. B. Interviews The DON and NHA were interviewed together on 2/29/24 at 11:35 a.m. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-The DON said on 2/19/24, there was no receptionist at the desk when Residents #1 and #2 eloped because the receptionist was bringing a visitor to a resident's room. She said the business office manager (BOM) told her the police had called and said they had two of the facility's residents. She went to the 400 hall and the nurse on duty said Resident #1 and Resident #2 were in activities. The DON said she went to activities and the residents were not there. She said they must have left activities and gone out the front door. She said Resident #2 had her car keys all the time, and Resident #1 liked to go in a car for rides. She said Resident #1 must have fallen when he eloped and a good Samaritan called the police. Resident #2 was brought back to the facility. She did not have her wander-prevention device on. -The DON said there was a lag time on the front door when it was opened, to allow people with wheelchairs to get through without the door closing on them. She said the door did not alarm when it was in the open position and she had timed it to take two minutes to close once opened. The DON believed that was how the residents left the facility. She said the facility had a plan to ensure the receptionist was always at the front door during the day until the door could be looked at by a door company. V. Facility failure to implement a comprehensive and effective plan to prevent future elopements Interviews, record review, and observations revealed multiple failures in the facility's response to Resident #1 and #2's elopement on 2/19/24. A. Failures identified 2/29/24 1. Staff training post 2/19/24 incident LPN #1 was interviewed on 2/29/24 at 9:27 a.m. She said she was from a staffing agency. LPN #1 said she did not know who was at risk for wandering, but the facility had a binder with pictures of those who were at risk for wandering. The Elopement binder at the nurses'station was reviewed on 3/4/24 at 10:00 a.m. The binder contained a photograph of Residents #1, #2, #3, #14, #15,#19, #20, #21, and #22. The binder contained an in-service sheet that documented, Elopement Training, see attached. However, there was no documentation attached. LPN #1 had signed the inservice. The unit manager (UM) was interviewed on 3/4/24 at 9:37 a.m. as she approached the desk where the binder was located. -The UM agreed there was no information attached to the in-service. She said she gave the staff a verbal in-service. The UM could not say how staff were educated on the days she was not present at the facility. She said she would add written education on elopement to the elopement binder for the staff to review. -The UM said she was aware of the elopement of Resident #1 and Resident #2 on 2/19/24. She said the NHA completed the investigation and she did not know what the outcome was. The UM said she thought both residents were supposed to have a wander-prevention device on and she thought they left through the front door. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-The UM said she did not know what the plan was to prevent future elopements because she was not involved in the investigation. The UM said she was responsible for educating the staff on who was at risk for elopement and to watch for things like aimless wandering or sitting by exit doors. 2. Wander-prevention devices Records for Residents #14, #15, and #21 were reviewed. All three residents were identified as at risk for wandering. The residents had orders for a wander-prevention device. However, there was no order or instruction on their care plans to check the function of the devices every shift, only to check the placement of the devices. Records for Resident #3 were reviewed and revealed on 2/21/24, a wandering assessment documented that Resident #3 was at risk of wandering with a wander risk score of 26 due to confusion, medications, and cognitive impairment. A score of 10 or higher was a wandering risk. An elopement care plan dated 2/20/24 documented Resident #3 was at risk for elopement related to dementia and forgetfulness. On 2/25/24, the care plan documented the elopement bracelet at all times, check placement every shift, check, check door alarms promptly. However, Resident #3 did not have an order for a wander-prevention device. 3. Wandering system On 2/29/24 at 11:30 a.m., the weekly exterior door checks were received from the maintenance supervisor (MS). The door checks read to check the operation of door monitors and resident wandering systems. The exterior door checks for 2/19/24 were stamped as completed on time 2/23/24 and included the main entrance/front door. Before 2/19/24, the door checks were documented as completed on 2/13/24 and completed on time 2/16/24. -There was no documentation to show the entrance/front door was checked after Resident #1 and #2 eloped on 2/19/24. On 2/29/24 at 9:00 a.m., there was no receptionist observed for several minutes at the front entrance, contrary to the facility investigation documents (see above) that read the facility's plan post 2/19/24 was to have the receptionist monitor the area during the day. On 2/29/24 at 11:35 a.m., the DON and NHA were interviewed together. -The DON confirmed the facility plan was to ensure the receptionist was always at the front door during the day until the door could be looked at by a door company. She acknowledged, however, that there was no receptionist at the front door today, 2/29/24 at 9:09 a.m. -The NHA said she has a receptionist at the desk monitoring the door until 5:00 p.m. and acknowledged there was no receptionist after 5:00 p.m. because the door automatically locks at 5:00 p.m. The DON, too, said at night the door could be locked and not opened, even by pushing on the door for 15 seconds. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/29/24 at 11:48 a.m. the front door was observed with the DON. The door was approached with a wander-prevention device in hand. The door did not react or alarm. Two more wander-prevention devices were obtained from the DON. The door was checked again with a different wander-prevention device. The door did not alarm or lock when approached with the wander-prevention device. The door was then opened. The door closed slowly, around 2 minutes. The door was approached with a wander-prevention device as it was closing. It did not alarm. On 2/29/24 at 12:34 p.m., eight residents who were assessed to need wander-prevention devices were observed with the UM. Resident #2, again, did not have a wander-prevention device on. Resident #3, who was assessed to be an elopement risk and had a care plan for a wander-prevention device (see above), did not have a wander-prevention device on. The UM said both residents should have had a wander-prevention device on. On 2/29/24 at 12:38 p.m., LPN #1, who was assigned to Resident #2, was interviewed again. She repeated that she worked for a staffing agency and she did not know Resident #2. She said she did not know if Resident #2 wore a wander-prevention device or had one on. On 2/29/24 at 12:55 p.m., the DON was interviewed again She said Resident #2 had a wander-prevention device yesterday and she must have removed it. She said she did not know what the plan was to keep Resident #2 safe if she was removing the wander-prevention device. On 2/29/24 at 1:00 p.m., the maintenance supervisor (MS) was interviewed. -The MS said he did not know if the front door locked automatically at 5:00 p.m. which the NHA had reported was the reason the facility only had a receptionist at the front desk until 5:00 p.m. He said he did not think the doors were locked automatically at 5:00 p.m. He said the doors should still open when the release bar on the front of the door was pressed for 15 seconds. He said he had never tested the doors after 5:00 p.m. to see if they were locked. -The MS said the front doors had been a problem since he started working at the facility in September 2023. He said sometimes the doors would not open even when a wander-prevention device was not nearby. He said he was not aware the door was not alarming when approached with a wander-prevention device (see above). He said he checked the facility doors leading to the exterior weekly to ensure the doors operated correctly and the wander-prevention system worked. On 2/29/24 at 1:35 p.m., the NHA was interviewed again. She looked up Residents #14, #15, and #21 on her computer. She said she did not see orders to check the function of the residents' wander-prevention devices, just to check the placement. She said the facility had reviewed residents at risk for wandering in the quality assurance and performance improvement (QAPI) meeting on 2/22/24. She said the committee reviewed residents for placement of wander-prevention devices but had not looked at checking the function of the devices. On 2/29/24 at 6:07 p.m., the regional director of plant operations (RDPO) was interviewed. He said the goal was to get the door to at least alarm with the approach of a wander-prevention device and the door was open. He said there was a sensor on the wall several feet before the front door that should trigger the door to alarm and lock but it was not working. He said the doors do not lock after 5:00 p.m. and always open when the release bar on the front of the door is pressed for 15 seconds. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	B. Failures identified after 2/29/24 1. Staff training On 3/4/24 at 9:34 a.m., the regional director of clinical services (RDCS) #1 was interviewed. RDCS #1 provided staff training records to prevent elopements pe[TRUNCATED]

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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** 41172 Based on record review and interviews, the facility failed to provide an effective pain management regimen in a manner consistent with professional standards of practice, resident-centered care plans and resident preferences for two (#17 and #8) of three residents reviewed for pain management out of 38 sample residents. The facility failed to ensure Resident #17 and Resident #8, both with a diagnosis of chronic pain, were assessed for pain accurately and administered pain medications as ordered. Both residents reported increased levels of pain. Resident #17's 2/19/24 pain assessment documented the resident had pain which affected her day to day activity. On 2/29/24, the resident reported she did not always get her pain medication as ordered. She said her pain affected her sleep and her ability to get around. Resident #8's 2/21/24 pain assessment documented the resident had pain which affected his sleep and his day to day activity. On 2/29/24, the resident reported he had gone without pain medications on several occasions. He said he was not able to sleep or move around much when he had increased pain. Due to the facility's failures to ensure Resident #17 and Resident #8's pain medications were consistently administered as ordered, both residents sustained increased pain. Findings include: I. Facility policy and procedure The Pain policy, revised October 2022, was received from the director of nursing (DON) on 3/5/24 at 4:09 p. m. It read in pertinent part, The physician and staff will identify individuals who have pain or who are at risk for having pain. This includes reviewing known diagnoses and conditions that commonly cause pain; for example, degenerative joint disease, rheumatoid arthritis, osteoporosis (with or without vertebral compression fractures), diabetic neuropathy, oral or dental pathology, and post-stroke syndromes). It also includes a review for any treatments that the resident currently is receiving for pain. With input from the resident to the extent possible, the physician and staff will establish goals of pain treatment; for example, freedom from pain with minimal medication side effects, less frequent headaches, or improved functioning, mood, and sleep. The nursing staff will identify any situations or interventions where an increase in the resident's pain may be anticipated. II. Resident #17 A. Resident status Resident #17, age greater than 65, was admitted on [DATE]. According to the February 2024 computerized physician orders (CPO), diagnoses included septic right knee, lumbar abscess and chronic pain syndrome. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	According to the 2/19/24 minimum data set (MDS) assessment, the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. She required substantial maximal assistance from staff with transfers, dressing, toileting and personal hygiene. She required moderate assistance from staff with bed mobility. The assessment documented she had pain which affected day to day activity. B. Resident interview Resident #17 was interviewed on 2/29/24 at 2:54 p.m. Resident #17 said the facility would run out of her scheduled and PRN (as needed) pain medication Norco (opioid pain medication). Resident #17 said the nurse would try to offer her muscle relaxers when the facility ran out of the Norco, however, she told them the muscle relaxer was not as effective as the pain medication. Resident #17 said she had two back surgeries for infections in her back, however, she continued to have back pain and chronic pain in her knees. Her pain level was 6 to 8 (on a scale of 1-10, with 10 being the worst pain) when she did not get the pain medication. She said it affected her sleep and her ability to get around when she had pain. Resident #17 said the lowest her pain level got was a two out of 10. C. Record review Review of Resident #17's February 2024 CPO revealed the following physician's orders: Hydrocodone-Acetaminophen oral tablet (Norco) 5-325 milligrams (mg). Give one tablet by mouth every four hours PRN for pain, ordered 1/30/24. -There were no parameters for when to give the medication. Celebrex capsule (Celecoxib) 100 mg. Give one capsule by mouth two times a day for pain, give with meals, ordered 2/19/24. Hydrocodone-Acetaminophen oral tablet (Norco) 5-325 mg. Give one tablet orally three times a day for chronic pain, ordered 2/20/24. The January 2024 and February 2024 medication administration records (MAR) documented the resident had received the Norco PRN pain medication for pain levels of 0 to 8 out of 10. The February 2024 MAR further revealed the resident was given Norco PRN two to three times per day from 2/1/24 until the order was changed to scheduled three times per day on 2/20/24. -Despite nursing staff documenting Resident #17 was administered Norco two to three times per day PRN, the resident's pain assessment levels on the MAR for the administration of the Norco were frequently documented at a 0 out of 10. From 2/20/24 (after the Norco PRN physician's order was changed to scheduled Norco) until 2/24/24, the Norco medication was signed off as administered on the February 2024 MAR each day, including three doses on 2/24/24. -However, review of the Norco narcotic count sheet revealed no Norco was administered on 2/24/24. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-On 2/20/24, at 8:31 a.m. and 4:49 p.m., Resident #17's Celebrex was documented as not administered for pain because it was not available. D. Staff interview The DON was interviewed on 3/6/24 at 10:23 a.m. She said she had compared the Norco narcotic count sheet to the February 2024 MAR. She said the resident had missed doses of Norco despite being signed off on the MAR as given. The DON said she found no evidence the Norco was taken from the facility's emergency medication supply which meant the pain medication was not administered to the resident. The DON said PRN pain medications should have parameters for when to give them. The DON said she would not expect Norco to be given for pain levels of zero. The DON said she would begin in-servicing the licensed nurses on pain control and medication administration. III. Resident #8 A. Resident status Resident #8, age 68, was admitted on [DATE]. According to the February 2024 CPO, diagnoses included osteoarthritis and chronic pain. According to the 2/21/24 MDS assessment, the resident was cognitively intact with a BIMS score of 15 out of 15. He was independent with bed mobility and transfers. He required set up assistance for the staff with toileting, dressing, and personal hygiene. He had pain and was on pain medication. The assessment documented pain affected the resident's sleep and day to day activity. B. Resident interview Resident #8 was interviewed on 3/4/24 at 10:15 a.m. Resident #8 said the nurses documented his pain medications (Oxycodone) and neurontin were given but they did not give him the medications. Resident #8 said sometimes the nurse would say they did not have the medications. He said he had gone without his pain medications for several days before. He said when he did not receive his pain medications he had increased pain at a pain level of 8 out of 10 and was not able to sleep or move around as much. Resident #8 said he had reported not receiving his pain medications consistently to the DON but he said he had never heard anything back from her. He said his pain levels were consistently at a level of 4 out of 10 when he received his pain medication but he always had pain. Resident #8 said his pain was never a pain level of 0 out of 10. C. Record review Review of Resident #8's February 2024 CPO revealed the following physician's orders: Gabapentin oral capsule 300 mg. Give 600 mg by mouth at bedtime for neuropathic pain, ordered 8/17/23. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Tizanidine oral tablet 2 mg. Give one tablet by mouth two times a day for muscle spasms, ordered 1/25/24. Oxycodone oral capsule (Oxycodone HCl) 5 mg. Give 10 mg by mouth four times a day for right knee pain, ordered 8/22/24. Review of Resident #8's electronic medical record (EMR) revealed the following progress notes: On 1/12/24 at 9:35 a.m. the nursing progress notes documented the resident did not get his oxycodone because it was on order. On 1/16/24 at 11:31 a.m., 3:02 p.m. and 8:00 p.m. the nursing progress notes documented Resident #8 did not get his scheduled oxycodone because it was on order from the pharmacy. On 1/26/24 at 4:05 p.m. the nursing progress notes documented the resident's Tizanidine for muscle spasms was not given because it was on order. On 1/28/24 at 4:40 p.m. the nursing progress notes documented the resident's Tizanidine for muscle spasms was not given because it was on order. On 2/1/24 at 7:30 p.m. the nursing progress notes documented the resident did not receive his gabapentin for nerve pain because it was on order. On 2/2/24 at 4:45 a.m. the nursing progress notes documented in a behavior note, the resident said I want all my medications. The nurse responded, If it is not on my cart, I can not give it to you. -The missing medications were not documented. -There were no further progress notes regarding action taken to get the medication or that the physician was notified for further orders. The oxycodone narcotic count sheets were reviewed for January 2024. -There was no oxycodone signed out for any of the four dose administration times on 1/12/24, and only one of the four dose administration times (8:00 a.m.) was signed out on 1/16/24. The January 2024 MAR documented the resident had a pain level of five on 1/16/24 at 10:00 p.m. when he did not receive his oxycodone. -The resident's pain levels for the rest of January 2024 and February 2024 were frequently documented as a 0 out of 10, despite the resident's report that his pain level was never below a 4 out of 10, even when he received pain medication (see resident's interview above). -However, Resident #8 reported his pain level never went below a 4 out of 10, even when he received pain medication (see resident's interview above). (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-The last comprehensive pain assessment completed for Resident #8, other than the 2/21/24 MDS assessment, was on 8/17/23, six months prior to the survey. The assessment documented that the resident had frequent pain at a level of 6 out of 10. -There was no documentation of the resident's pain goals or things that made pain worse or relieved pain. D. Staff interview The DON was interviewed on 3/5/24 at 2:06 p.m. The DON said the licensed nurses should have notified her when they did not have the pain medication for Resident #8. She said the medication could be received from the pharmacy within two hours when requested STAT (urgent) from the pharmacy. The DON said comprehensive pain assessments were completed on admission, quarterly and as needed. She said pain was assessed every shift and documented on the MAR. She said PRN pain medication should have parameters for when to administer the medication. IV. Additional interviews The DON was interviewed again on 3/5/24 at 4:01 p.m. She said the regional nurses had reviewed the MARs and progress notes for Resident #17 and Resident #8 and said the residents did not receive their pain medications as ordered. She said this was an issue. The DON said she would investigate further to see if there was a trend with specific nurses. She said the facility had an emergency medication system where the medication could have been obtained. The DON said the nurses should have notified the provider for further orders when the pain medication was not available. The DON said she would begin educating the staff on steps to take when a narcotic pain medication was not available and obtaining parameters for when to administer pain medication. The DON said she was not sure if the frequent pain level of 0 out of 10 documented on the MARs for both residents was accurate.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41172 Based on record review and interviews, the facility failed to ensure residents were kept free from significant medication errors for five (#8, #9, #3, #17 and #21) of five residents reviewed out of 38 sample residents. Specifically, the facility failed to ensure Residents #8, #9, #3, #17 and #21 received all prescribed medications, which resulted in significant medication errors of omission. Findings include: I. Facility policy The Unavailable Medication policy, revised February 2023, was received on 3/6/23 at 10:32 a.m. from the director of nursing (DON). The policy documented in pertinent part, Medications may be unavailable for a number of reasons. Staff shall take immediate action when it is known that the medication is unavailable. Determine reason for unavailability, length of time medication is unavailable, and what efforts have been attempted by the facility or pharmacy provider to obtain the medication. Notify physician of inability to obtain medication upon notification or awareness that medication is not available. Obtain alternative treatment orders and/or specific orders for monitoring residents while medication is on hold. Determine whether a resident has home supply. Obtain orders to use home supply. Administer first dose after the pharmacist has verified that the medication is correct with respect to name, dose, and form of medication. If a resident misses a scheduled dose of the medication, staff shall follow procedures for medication errors, including physician/family notification, completion of a medication error report, and monitoring the resident for adverse reactions to omission of the medication. II. Resident #8 A. Resident status Resident #8, age 68, was admitted on [DATE]. According to the March 2024 computerized physician orders (CPO), diagnoses included osteoarthritis and chronic pain, diabetes, major depression and bipolar disorder. According to the 2/21/24 minimum data set (MDS) assessment, the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. (continued on next page)

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Winding Trails Post Acute	2800 Palo Pkwy Boulder, CO 80301

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Resident interview Resident #8 was interviewed on 3/4/24 at 9:34 a.m. Resident #8 said he frequently did not get all his medications. He said the nurses signed it off on the MAR but he did not really get the medications. He said he had gone without medications such as clonazepam and oxycodone. C. Record review Review of Resident #8's March 2024 CPO revealed the following physician's orders: Quetiapine Fumarate (Seroquel) oral tablet 200 milligrams (mg). Give 200 mg by mouth at bedtime for bipolar disorder, ordered 8/17/23. Oxycodone oral capsule (Oxycodone HCl) 5 mg. Give 10 mg by mouth four times a day for right knee pain, ordered 8/22/24. Clonazepam 1 mg, give one tablet at bedtime for bipolar disorder, ordered 8/17/23. Tizanidine oral tablet 2 mg. Give one tablet by mouth two times a day for muscle spasms, ordered 1/25/24. Glipizide 10 mg by mouth one time per day for diabetes, ordered 8/18/23. Loratadine 10 mg, give one tablet by mouth at bedtime for allergies, ordered 12/28/23. Gabapentin oral capsule 300 mg. Give 600 mg by mouth at bedtime for neuropathic pain, ordered 8/17/23. Review of Resident #8's nursing progress notes revealed multiple medications were not administered due to the medications being unavailable or on order from the pharmacy. Quetiapine Fumarate (Seroquel) oral tablet 200 milligrams was documented as not given because the medication was on order on: -1/7/24 at 8:43 p.m.; -1/11/24 at 8:19 p.m.; and, -1/15/23 at 9:17 p.m. Oxycodone oral capsule 5 mg was documented as not given because the medication was on order on: -1/12/24 at 9:35 a.m.; -1/16/24 at 11:31 a.m.; -1/16/24 at 3:02 p.m.; and, (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-1/16/24 at 8:03 p.m. Cross-reference F697 for failure to manage pain. Clonazepam 1 mg was documented as not given because the medication was not available or was on order on: -1/23/24 at 11:20 p.m.; -1/24/24 at 9:28 p.m.; and, -1/25/24 at 10:04 p.m. Tizanidine oral tablet 2 mg was documented as not given because the medication was on order on: -1/26/24 at 8:38 a.m.; -1/26/24 at 4:05 p.m.; -1/28/24 at 7:51 a.m.; and, -1/28/24 at 4:40 p.m. Glipizide 10 mg was documented as not given because the medication was on order on: -1/27/24 at 8:13 a.m.; -1/28/24 at 7:50 a.m.; -2/4/24 at 7:28 a.m.,; and, - 2/26/24 at 9:38 a.m. Loratadine 10 mg was documented as not given because the medication was on order on: -1/28/24 at 4:40 p.m.; -1/30/24 at 7:51 p.m.; and, -1/31/24 at 7:51 p.m. Gabapentin 600 mg was documented as not given because the medication was not available on: -2/1/24 at 7:30 p.m. On 2/2/24 at 4:45 a.m. a behavior progress note documented the resident said I want all my medications and the nurse responded if it is not on my cart I can not give it to you. The resident requested a copy of his medication administration records (MAR). (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-There was no documentation in the progress notes the provider was notified for further orders when the medications were not available or on order from the pharmacy. III. Resident #9 A. Resident status Resident #9, age 77, was admitted on [DATE] and readmitted on [DATE]. According to the March 2024 CPO, diagnoses included chronic pain and edema (swelling). The 1/17/24 MDS assessment revealed the resident had mild cognitive impairment with a BIMS score of 14 out of 15. B. Record review Review of Resident #9's March 2024 CPO revealed the following physician's orders: Potassium chloride extended release tablet 20 meq (milliequivalent). Give one tablet by mouth for hypokalemia (low potassium), ordered 6/14/23. Lasix 40 mg by mouth one time per day for edema (swelling), ordered 1/5/24. Cymbalta delayed release capsule 60 mg. Give one capsule one time per day for pain, ordered 1/5/24. Review of Resident #9's nursing progress notes revealed multiple medications were not administered due to the medications being unavailable or on order from the pharmacy. Potassium chloride extended release tablet 20 meq was documented as not given because the medication was on order on: -1/1/24 at 2:04 p.m.; -1/3/24 at 10:54 a.m.; -1/4/24 at 8:19 a.m.; -1/7/24 at 7:14 a.m.; -1/10/24 at 7:27 a.m.; -1/19/24 at 7:31 a.m.; -1/20/24 at 7:16 a.m.; -1/21/24 at 7:46 a.m.; -1/22/24 at 12:15 p.m.; (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-1/23/24 at 2:49 p.m.; -1/24/24 at 7:14 a.m.; -1/25/24 at 7:23 a.m.; -1/26/24 at 8:14 a.m.; -1/29/24 at 7:54 a.m.; -1/30/24 at 9:27 a.m.; -1/31/24 at 7:38 a.m.; and, -2/4/24 at 8:27 a.m. Lasix 40 mg was documented as not given because the medication was unavailable or on order on: -1/10/24 at 7:29 a.m.; -1/18/24 at 8:29 a.m.; and, -1/20/24 at 7:15 a.m. Cymbalta delayed release capsule 60 mg was documented as not given because the medication was on order on: -2/23/24 at 10:40 a.m. -There was no documentation in the progress notes the provider was notified for further orders when the medications were not available or on order from the pharmacy. IV. Resident #3 A. Resident status Resident #3, age 71, was admitted on [DATE], and readmitted on [DATE]. According to the March 2024 CPO, diagnoses included intracranial hemorrhage, schizoaffective disorder, hypertension and COVID-19. According to the 2/21/24 MDS assessment, the resident had severe cognitive impairment with a BIMS score of seven out of 15. B. Record review Review of Resident #3's March 2024 CPO revealed the following physician's orders: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ingrezza 80 mg. One capsule at bedtime for dyskinesia (uncontrolled involuntary muscle movement), ordered 12/6/21. Atenolol 25 mg by mouth one time per day for hypertension (high blood pressure), ordered 12/1/21. Omeprazole 20 mg one time per day for gastric reflux disease (GERD), ordered 12/1/21. Ipratropium albuterol solution 0.5 to 2.5 mg per 3 milliliters (ml). Inhale one dose every six hours for RSV (respiratory syncytial virus) and COVID-19 for 7 days, ordered 2/22/24. Review of Resident #3's nursing progress notes revealed multiple medications were not administered due to the medications being unavailable or on order from the pharmacy. Ingrezza 80 mg was documented as not given because the medication was on order on: -1/16/24 at 10:53 p.m.; and, -1/17/24 at 7:39 p.m. Atenolol 25 mg was documented as not given because the medication was on order on: -1/22/24 at 7:33 a.m.; -1/26/24 at 7:09 a.m.; and, -2/6/24 at 11:49 a.m. Omeprazole 20 mg was documented as not given because the medication was not available on: -2/16/24 at 9:09 p.m. Ipratropium albuterol solution 0.5 to 2.5 mg per 3 ml was documented as not given because the medication was not available on: -2/28/24 at 4:46 a.m. -There was no documentation in the progress notes the provider was notified for further orders when the medications were not available or on order from the pharmacy. V. Resident #17 A. Resident status Resident #17, age greater than 65, was admitted on [DATE]. According to the February 2024 CPO, diagnoses included septic right knee, lumbar abscess and chronic pain syndrome. According to the 2/19/24 MDS assessment, the resident was cognitively intact with a BIMS score of 14 out of 15. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Resident interview Resident #17 was interviewed on 2/29/24 at 2:54 p.m. Resident #17 said she did not always get her prescribed medications such as Norco. C. Record review Review of Resident #17's March 2024 CPO revealed the following physician's orders: Potassium extended release 20 meq. Give one tablet by mouth one time a day for hypokalemia (low potassium), ordered 9/12/23. Celebrex capsule (Celecoxib) 100 mg. Give one capsule by mouth two times a day for pain, give with meals, ordered 2/19/24. Hydrocodone-Acetaminophen oral tablet (Norco) 5-325 mg. Give one tablet orally three times a day for chronic pain, ordered 2/20/24. Review of Resident #17's nursing progress notes revealed multiple medications were not administered due to the medications being unavailable or on order from the pharmacy. Potassium extended release 20 meq was documented as not given because the medication was on order on: -1/1/24 at 8:49 a.m.; - 2/4/24 at 8:53 a.m.; and, -3/1/24 at 7:49 a.m. Celebrex capsule (Celecoxib) 100 mg was documented as not given because the medication was on order on 2/20/24 at 4:49 p.m. Hydrocodone-Acetaminophen oral tablet (Norco) 5-325 mg was documented as being given for all three doses on 2/24/24. -However, review of the Norco narcotic count sheet revealed no Norco was given on 2/24/24. -There was no documentation in the progress notes the provider was notified for further orders when the medications were not available or on order from the pharmacy. VI. Resident #21 A. Resident status Resident #21, age less than 65, was admitted on [DATE] and readmitted on [DATE]. According to the February 2024 CPO, diagnoses included Alzheimer's dementia, bipolar disorder and drug induced dyskinesia (involuntary movement). (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 12/18/23 MDS assessment revealed the resident was severely cognitively impaired with a BIMS score of four out of 15. B. Record review Review of Resident #21's February 2024 CPO revealed the following physician's orders: Propranolol 10 mg. Give 10 mg by mouth two times a day for Tardive dyskinesia, ordered 6/7/23. Zyprexa 5 mg. Give 5 mg by mouth in the afternoon for delusions, aggressive behaviors and false beliefs, ordered 1/12/24. Venlafaxine extended release 24 hours, 37.5 mg. Give 37.5 mg by mouth one time daily for inappropriate sexual behavior and manic mood swings, ordered 8/17/23. Review of Resident #21's nursing progress notes revealed multiple medications were not administered due to the medications being on order from the pharmacy. Propranolol 10 mg was documented as not given because the medication was on order on: -1/5/24 at 7:41 a.m.; and, -1/6/24 at 8:02 a.m. Zyprexa 5 mg was documented as not given because the medication was on order on: -1/27/24 at 4:26 p.m.; -1/28/24 at 5:11 p.m.; and, -1/29/24 4:45 p.m. Venlafaxine extended release 24 hours, 37.5 mg was documented as not given because the medication was on order on: -1/31/24 at 6:32 a.m.; and, -2/1/24 at 8:11 a.m. -There was no documentation in the progress notes the provider was notified for further orders when the medications were not available or on order from the pharmacy. VII. Facility record review The 2/29/24 resident council minutes were received from the NHA on 2/29/24 at 10:00 a.m. The notes documented the residents had concerns with missing medications. -There was no follow up on the concern. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	VIII. Staff interviews A frequent visitor (FV) was interviewed on 3/4/24 at 2:38 p.m. The FV said she had heard many complaints from residents regarding medications not being available. Licensed practical nurse (LPN) #5 was interviewed on 3/4/24 at 2:40 p.m. LPN #5 said if a medication was not available the nurse should see if it was available in the emergency medication kit. She said if it was not in the emergency medication kit the nurse should notify the provider. LPN #5 said there were many issues with the pharmacy. She said if staff reordered a medication and the pharmacy could not refill it for some reason the pharmacy did not notify the facility. She said if a refill request was sent to the pharmacy five days before a medication ran out, sometimes the facility did not receive the medication for seven days. LPN #5 said she had expressed concerns to the pharmacy consultant who visited but there had been no resolution. LPN #4 was interviewed on 3/5/24 at 1:50 p.m. LPN #4 said medications were reordered by faxing the pharmacy the medication that was needed when the medication had a few doses remaining. She said there had been many issues with medications not being available and other licensed nurses told her they had been borrowing medications from other residents. LPN #4 said the medication refills did not come timely. The director of nursing (DON) was interviewed on 3/5/24 at 1:59 p.m. The DON said she was not aware of an issue with medications not being available. She said if a medication was not available the nurse should call her, the pharmacy and the provider. The DON said nurses should not borrow medications from other residents. -A voice mail message was left for the account manager of the pharmacy on 3/6/24 at 1:33 p.m., however, the phone call was not returned during the survey.

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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. 41172 Based on observations, record review and interviews, the facility failed to ensure food items were stored and served under sanitary conditions in the main kitchen. Specifically, the facility failed to ensure staff correctly and accurately tested for the correct parts per million (ppm) of the chemical sanitizer used to clean equipment and surfaces where food was prepared. Findings include: I. Professional reference The Colorado Department of Public Health and Environment (2019) The Colorado Retail Food Establishment Rules and Regulations, retrieved on 3/13/24 from: https://www.colorado.gov/pacific/sites/default/files/DEHS_RetailFd_6CCR10102_RFFC_EffJan2019.pdf, read in pertinent part, Chemical sanitizers that are used to sanitize equipment and utensils shall be provided and available for use during all hours of operation. A chemical sanitizer used in a sanitizing solution for a manual or mechanical operation at contact times and be used in accordance with the EPA registered label use instructions. Concentration of the sanitizing solution shall be accurately determined by using a test kit or other device. II. Observations and interviews On 3/7/24 at 11:31 a.m., two red tubs of quat (benzalkonium chloride) solution were sitting on tables in the main kitchen. The dietary director (DD) said the solution was used to clean equipment and the metal tables where food was prepared. She said the staff checked the quat solution each shift and it should register 200 ppm. The DD said there was a machine that automatically mixed the solution with water and the staff only needed to refill the red buckets with it. -The solution was tested with test strips by the DD. The solution did not register on the strip. It remained at 0 ppm. -The DD dumped out the solution and retested the new solution with a new test strip. The new test strip continued to read 0 ppm. -The DD obtained a new package of test strips and tested the quat solution again. The solution tested 0 ppm again. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The DD manager said she would call the company that installed the machine which dispensed the quat solution and have them come check the machine to figure out if there was an issue. She said she would use microkill wipes to clean the equipment and food preparation services in the meantime. She said she did not know if the wipes were food safe but she would find out. On 3/7/24 at 2:31 p.m., the DD said she was going to the store to purchase food safe wipes and would not use the microkill wipes because they were not food safe. The DD was interviewed again on 3/7/24 at 3:20 p.m. She said the company that installed the machine which dispensed the quat solution had come to inspect the machine. She said the problem was the facility had been using the wrong test strips to test the solution. The DD said the correct test strips had been obtained and the quat solution now tested at 200 ppm. -The test logs for February 2024 documented the quat solution tested at 200 ppm each shift. The DD said the test logs could not be accurate given the facility had the wrong test strips. She said she would be educating the dietary staff on how to test the quat solution. The DD did not know how long the facility had been using the wrong test strips.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 41172 Based on observation and interviews, the facility failed to effectively administer its resources to attain the highest practicable wellbeing for each resident. Specifically, the facility failed to: -Implement and maintain safety measures to prevent elopements with significant injury; -Prevent, report and investigate allegations of resident to resident abuse; and, -Provide sufficient leadership to address and/or avoid multiple significant concerns. Findings include I. Quality of care -Cross reference F689 for failure to ensure residents were free from accidents and elopement which caused major injury. -Cross reference F697 for failure to implement an effective pain management program. II. Freedom from abuse -Cross-reference F600 for failure to protect residents from physical abuse. -Cross-reference F609 for failure to report alleged violations. -Cross-reference F610 for failure to investigate alleged violations. III. Nursing services -Cross-reference F760 for failure to ensure residents were free from significant medication errors. IV. Training requirements -Cross-reference F730 for failure to ensure certified nurse aides (CNA) had completed required 12 hour training based on their date of hire and annual performance review. -Cross reference F940 for failure to ensure all direct and indirect care staff were trained in dementia care, mental health diagnoses and substance abuse. V. Quality assurance and performance improvement (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Cross reference F867 for failure to implement effective systems to obtain feedback, use data, and take action to conduct structured, systematic investigations and analysis of underlying causes or contributing factors of problems affecting facility-wide processes that impact quality of care, quality of life, and resident safety. VI. Interviews A frequent visitor (FV) was interviewed on 3/4/24 2:38 p.m. The FV said she had several serious complaints regarding the facility. She said she had heard many residents complain about not getting their medications and that the environment was bad. She said residents and staff were afraid of retaliation from the administration for reporting things such as abuse. The FV said the facility had had a large influx of admissions with mental health and substance abuse diagnoses but the staff had not been offered any training in those areas. The FV said many residents had complained about roommates with mental health issues and requested to be moved to a new room, however, she said the residents' requests to move rooms were not being honored. The FV said Resident #7 was found with a blanket being held around her head by Resident #6. The resident could not defend herself due to her immobility. She said Resident #6 was then moved to another hall where she pushed Resident #3 down. She said the resident had head trauma and had to get 12 stitches. The FV said she saw his face which was completely black and blue. The FV said the facility staff told her they should report the abuse as a fall by the DON. The FV said neither she nor the police were notified of the incident. (Cross-reference F600 and F610). The FV said she was concerned for the safety of the residents and the staff were being intimidated and afraid to speak up. The FV was interviewed again on 3/6/24 at 11:43 a.m. The FV said the NHA led the facility by fear and retribution. The staff had been told during the current survey there would be consequences for talking to the state. She said the NHA dismissed what the staff and residents told her. Resident #17 was interviewed on 2/29/24 at 2:54 p.m. Resident #17 said Resident #4 threatened to harm her but there was no follow up by the administration. She said she had missed multiple doses of medication including pain medication (cross reference F697 and F760 significant medication errors). Resident #17 said the NHA and DON were aware of her concerns but there was no follow up. She said when NHA was dismissive of her concerns when she reported them and Resident #17 was made to feel like she was the problem. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winding Trails Post Acute	2800 Palo Pkwy Boulder, CO 80301

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #8 was interviewed on 3/4/24 at 10:15 a.m. He said he was told many staff had resigned due to poor management. He said he had missed several doses of his medications including pain medications. He said he had reported this to the DON but there was no follow up. He said a resident was beaten up by a female resident and the staff told him they were instructed by the DON not to call the police. He said there was a resident who drank alcohol and smoked in his room. He said residents and staff were fearful of him but nothing had been done to address the concerns. Resident #8 said the NHA did not follow up on concerns with abuse or other resident behaviors. He said she dismissed things and talked down to people. He said the corporation that provided oversight to the building needed to know what was happening at the facility. The restorative nurse aide (RNA) was interviewed on 3/7/24 at 1:00 p.m. The RNA said he was afraid to be seen talking to the state. He said the staff had been threatened and feared retaliation if they spoke up and he needed his job. He said one of the main problems was the lack of communication by the DON and the NHA. He said the NHA was overpowering conversations, and shutting down concerns reported by the staff. The RNA said things were falling apart. He said roommates were often put together who were not appropriate such as putting those with behaviors in with residents who were unhappy with the behaviors. He said abuse by Resident #6 had not been thoroughly investigated and the staff had been told to document the abuse as a fall by the DON. The RNA said there had been an increase in admissions of residents who had mental health conditions and behaviors but no training had been provided to the staff (cross reference F940). He said many staff were afraid of retaliation by the facility and were not going to say anything Licensed practical nurse (LPN) #4 was interviewed on 3/5/24 at 1:50 p.m. LPN #1 said she was concerned about the NHA finding out she was discussing things with the state surveyors. She said Resident #6 beat up Resident #3. She said the police were never called but a family member had heard about the abuse and called the police. She said the facility was admitting a lot more residents with mental health issues and behaviors but the staff had not received any training on how to handle the residents' behaviors. The NHA and DON were interviewed on 3/6/24 at 2:12 p.m. The NHA said the elopements were discussed but not in enough detail to identify and correct all of the issues such as Resident #2 removing her wanderguard. The NHA said she was not aware the smoking assessments had not been completed timely, and smoking assistive devices were not provided. She said they started accepting residents who smoked a few months ago but had not reviewed what the smoking program would entail. The NHA said the multiple missed medications and unavailability of medications was not identified. The NHA said the abuse investigations needed to be more thorough and she could not recall if she had reported them to the state or police.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 41172 Based on record review and interviews, the facility failed to conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. Specifically, the facility failed to develop a facility assessment which included all resources, education, staff competencies and facility based risk assessments. Findings include: I. Facility policy and procedure -The Facility Assessment policy was requested from the nursing home administrator (NHA) on 3/6/24 at 8:45 a.m. and was not received by the end of the survey on 3/7/24. II. Record review The Facility Assessment, last reviewed by the facility on 3/1/24 (during the survey), was received from the NHA on 3/6/24 at 8:45 a.m. The facility assessment failed to include the following: -Staff competencies that were necessary to provide the level and types of care needed for the resident population or include the staff training program to ensure any training needs were met for all new and existing staff including those presidents with substance abuse or who where exit seeking, wandered; -Staff trainings/education necessary to provide the level and types of support and care needed for the resident population; and, -Identify facility resources needed and equipment to provide competent resident support during day-to-day operations and emergencies including the facility's wander prevention system. III. Staff interviews The NHA was interviewed on 3/6/24 at 8:45 a.m. The NHA said the facility assessment had many missing components. She said the facility assessment had several areas that were missing and had not been completed on the template used. The NHA said the facility assessment did not include trainings or competencies for the different staff members, information on the facility wander prevention system, facility or community risk assessment using an all hazards risk approach, description of the infection prevention and control program, list of contracts, recruitment and retention of medical practitioners, technology resources, ethnic, cultural, or religious considerations. (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The NHA said the emergency preparedness portion of the facility assessment had missing components such as a facility map. The NHA said she was not aware all of these items needed to be in the facility assessment.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 41172 Based on interviews and record review, the facility failed to ensure an effective quality assurance program to identify and address facility compliance concerns was implemented in order to facilitate improvement in the lives of nursing home residents through continuous attention to quality of care, quality of life and resident safety. Specifically, the quality assurance performance improvement (QAPI) program committee failed to identify and address concerns related to quality of life and quality of care. Findings include: I. Cross-reference citations Cross-reference F689: The facility failed to ensure resident safety with accident hazards. The facility failed to ensure residents were assessed accurately and interventions were in place to prevent further elopements after two residents eloped, resulting in one resident sustaining a fracture. The facility's failure to protect residents from accident hazards created an immediate jeopardy (IJ) situation. Additionally, the facility failed to ensure residents were assessed timely for smoking safety and provided smoking assistive devices. Furthermore, the facility failed to keep chemicals and used razors secured safely. Cross-reference F600: The facility failed to prevent abuse resulting in actual harm. Cross reference F697: The facility failed to manage residents' pain resulting in actual harm. Cross-reference F607: The facility failed to notify staff of their right to be free of retaliation for reporting abuse. Cross-reference F609: The facility failed to report allegations of abuse to officials including the State Survey Agency. Cross-reference F610: The facility failed to thoroughly investigate allegations of resident verbal and physical abuse. Cross-reference F760: The facility failed to prevent significant medication errors. Cross-reference F835: The facility failed to provide adequate administration and follow up through action and inaction. Cross-reference F838: The facility failed to ensure an accurate and complete facility assessment was completed to determine what resources were necessary to care for its residents competently during both day-to-day operations and emergencies. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Cross reference F940: The facility failed to ensure all staff received training to care for the resident population including dementia care, substance abuse and mental health. Cross reference F947: The facility failed to ensure nurse aides had 12 hours of education annually based on their date of hire and annual performance review. II. Facility policy and procedure The QAPI policy was requested from the NHA on 3/6/24 at 2:12 p.m. -The policy was not received by the end of the survey on 3/7/24. III. Repeat deficiencies Review of the facility's regulatory record revealed it failed to operate a QAPI program in a manner to prevent repeat deficiencies. F689 for Accident hazards During a recertification survey on 4/19/22, F689 was cited at a D level scope and severity, a potential for more than minimal harm, isolated. During an abbreviated survey on 3/23/23, F689 was cited at a G level scope and severity, actual harm. During a recertification survey on 6/15/23, F689 was cited at an E level scope and severity, a potential for more than minimal harm, pattern. During an abbreviated survey on 11/20/23, F689 was cited at a D level scope and severity, a potential for more than minimal harm, isolated. During an abbreviated survey on 3/7/24, cited at a J level scope and severity, immediate jeopardy to resident health and safety, isolated. F697 Pain management During a recertification survey on 6/15/23, F697 was cited at an E level scope and severity, a potential for more than minimal harm, pattern. During an abbreviated survey on 3/7/24, F697 was cited at a G level scope and severity, actual harm. F838 Facility assessment During a recertification survey on 4/19/22, F838 was cited at a F level scope and severity, a potential for more than minimal harm, widespread. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an abbreviated survey on 3/7/24, F838 was cited at a F level scope and severity, a potential for more than minimal harm, widespread. F835 Administration During a recertification survey on 4/19/22, F835 was cited at a G level scope and severity, actual harm. During an abbreviated survey on 3/7/24, F835 was cited at a F level scope and severity, a potential for more than minimal harm, widespread. F867 QAPI During a recertification survey on 6/15/23, F867 was cited at a F level scope and severity, a potential for more than minimal harm, widespread. During a recertification survey on 4/19/22, F867 was cited at a G level scope and severity, actual harm. During an abbreviated survey on 3/7/24, F867 was cited at a F level scope and severity, a potential for more than minimal harm, widespread. IV. Interviews The nursing home administrator (NHA) and the director of nursing (DON) were interviewed together on 3/6/24 at 2:12 p.m. The NHA said the elopements were discussed at QAPI, but not in enough detail to identify and correct all of the issues such as Resident #2 removing her wanderguard. The NHA said she was not aware the smoking assessments had not been completed timely and smoking assistive devices were not provided. She said they started accepting residents who smoked a few months ago but the QAPI committee had not reviewed what the smoking program would entail. The NHA said the multiple missed medications and unavailability of medications was not identified or reviewed at QAPI. The NHA said the abuse investigations needed to be more thorough, however, she said that was not identified or reviewed at the QAPI meetings. The medical director (MD) was interviewed on 3/11/24 at 11:44 a.m. The MD said he thought the QAPI committee talked briefly, on 2/22/24, about the elopements that had occurred on 2/19/24. The MD said he did not realize the facility was now accepting residents who smoked. He said the facility had been a smoke free facility and he had not been informed of the change. The MD said he had not been advised of the multiple abuse allegations and altercations that had occured in the last two months. He said he should have been notified and the abuse should have been reviewed at QAPI. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The MD said he was not aware the facility was having issues obtaining medications timely for residents resulting in missed doses. He said this should have been discussed at QAPI. The MD was not aware the facility had not done training on substance abuse or dementia care despite the increased admission of residents with those diagnoses.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 41172 Based on record review and interviews, the facility failed to develop, implement and maintain an effective training program for all staff based on the facility assessment and resident population. Specifically, the facility failed to ensure all direct and non-direct care staff received training in dementia care, substance abuse and behavior management. Findings include: I. Facility policy The In-Service Training Policy, revised August 2022, was received from the regional director of clinical services (RDCS) #1 on 3/11/24 at 11:44 a.m. The policy documented in pertinent part, Required training topics include the following: Behavioral health, dementia management. Training requirements are met prior to staff providing services to residents, annually, and as necessary based on the facility assessment. Based on the outcome of the facility assessment, additional training may include substance abuse. II. Record review Staff training records related to behavior management, dementia and substance abuse were requested from RDCS #1 on 3/7/24 at 10:46 a.m. -RDCS #1 said she was unable to find any documentation indicating the facility had provided the staff with training for behaviors, substance abuse or dementia. The Facility Assessment, last reviewed 3/1/24 (during the survey), was received from the NHA on 3/6/24 at 8:45 a.m. -The facility assessment did not identify substance abuse as part of the resident population served, despite the multiple residents with known current or history of substance abuse (cross-reference F838 for failure to complete a comprehensive facility assessment). III. Interviews A frequent visitor (FV) was interviewed on 3/4/24 2:38 p.m. The frequent visitor said there had been a large influx of admissions for residents with mental health diagnoses with behaviors and substance abuse diagnoses but the staff had not been offered any training in how to work with the residents. (continued on next page)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The social services director (SSD) was interviewed on 3/5/24 at 11:00 a.m. The SSD said the facility had been accepting an increased number of residents with behaviors and substance abuse issues in the last few months. He said the facility had not provided any education on mental health care and behaviors or substance abuse to the staff. He said he would have thought the facility would have provided training on behavior management and things to look for and do for substance abuse but no training had been offered. The restorative nurse aide (RNA) was interviewed on 3/7/24 at 1:00 p.m. The RNA said there had been an increase in admissions of residents who had mental health conditions and behaviors but no training had been provided to him or the other staff.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 48458 Based on record review and interviews, the facility failed to ensure nurse aides received 12 hours of training based on annual performance evaluations and facility assessment. Specifically, the facility failed to ensure certified nurse aides (CNAs) #2, #3, #4, #5 and #6 received at least 12 hours of training. Findings include: I. Facility policy and procedure The In-Service Training, All Staff policy, revised August 2022, was provided by the regional director of clinical services (RDCS #1) on 3/11/24 at 11:44 a.m. It read in pertinent part: All staff are required to participate in regular in-service education. The primary objective of the in-service training is to ensure that staff are able to interact in a manner that enhances the resident's quality of life and quality of care and can demonstrate competency in the topic areas of the training. Required training topics include the following: -Effective communication with residents and family (direct care staff) -Resident rights and responsibilities, preventing abuse, neglect, exploitation, and misappropriation of resident property including: (1) activities that constitute abuse, neglect, exploitation or misappropriation of resident property; (2) procedures for reporting incidences of abuse, neglect, exploitation or misappropriation of resident property; and (3) dementia management and resident abuse prevention. -Elements and goals of the facility QAPI (quality assurance performance improvement) program; -The infection prevention and control program standards, policies and procedures; -Behavioral health; and -The compliance and ethics program standards, policies and procedures. (Compliance and ethics training is conducted annually when this organization is operating five or more facilities.) (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Training requirements are met prior to staff providing services to residents, annually, and as necessary based on the facility assessment. II. Record review The Abuse reporting in-service training dated 7/6/23 for CNAs #2, #3, #4, #5 and #6 was provided by RDCS #1 on 3/7/24 at 10:46 a.m. -CNA #2 was hired 8/14/89; -CNA #3 was hired 4/7/08; -CNA #4 was hired 6/24/10; -CNA #5 was hired 11/14/16; and, -CNA #6 was hired 7/20/22. -The training document did not include the length of abuse training. -Additional annual training documentation was not provided for these CNAs by exit on 3/7/24. III. Staff interviews RDCS #1 was interviewed on 3/7/24 at 10:46 a.m. She said she she did not have documentation for the five CNAs requested (#2, #3, #4, #5 and #6) for completion of 12 hours of annual training. RDCS #1 was interviewed on 3/7/24 at 11:10 a.m. She said the building had new ownership and annual evaluations had not been done for CNAs. She said she was not able to obtain annual evaluations and training records from the previous owner. She said the new company would begin tracking the CNAs' education.