

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065267	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/15/2024
NAME OF PROVIDER OR SUPPLIER  Winding Trails Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Plan the resident's discharge to meet the resident's goals and needs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43135</p> <p>Based on record review and interviews, the facility failed to develop and implement an effective discharge plan for one (#3) of three residents out of three sample residents reviewed for discharge planning.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> <li>-Provide an appropriate discharge process for Resident #3; and,</li> <li>-Notify the family that Resident #3 was transferred to another skilled nursing facility until after the resident had already been transferred.</li> </ul> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Discharge Summary and Plan policy, revised October 2022, was provided via email by the director of nursing (DON) on 10/14/24 at 11:33 a.m. It read in pertinent part,</p> <p>When a resident's discharge is anticipated, a discharge summary and post-discharge plan is developed to assist the resident with discharge.</p> <p>Policy Interpretation and Implementation</p> <p>The discharge summary includes a recapitulation of the resident's stay at the facility and a final summary of the resident's status at the time of the discharge in accordance with established regulations governing release of resident information and as permitted by the resident.</p> <p>Discharge potential (the expectation of discharging the resident from the facility within the next three months.</p> <p>Every resident is evaluated for his or her discharge needs and has an individualized post-discharge plan. The post-discharge plan is developed by the care planning/interdisciplinary team with the assistance of the resident and his or her family and includes:</p> <ul style="list-style-type: none"> <li>-Where the individual plans to reside;</li> </ul> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Arrangements that have been made for follow-up care and services;</p> <p>-A description of the resident's stated discharge goals;</p> <p>-The degree of caregiver/support person availability, capacity and capability to perform required care; and,</p> <p>-How the IDT (interdisciplinary team) will support the resident or representative in the transition to post-discharge care.</p> <p>The resident/representative is involved in the post-discharge planning process and informed of the final post-discharge plan.</p> <p>The resident or representative (sponsor) is asked to provide the facility with a minimum of a seventy-two (72) hour notice of a discharge to assure that an adequate discharge evaluation and post-discharge plan can be developed.</p> <p>A member of the IDT reviews the final post-discharge plan with the resident and family at least twenty four (24) hours before the discharge is to take place.</p> <p>II. Resident #3</p> <p>A. Resident status</p> <p>Resident #3, age 79, was admitted on [DATE]. According to the May 2024 computerized physician orders (CPO), diagnoses included acute kidney failure, dementia without behavioral disturbances, type 2 diabetes mellitus, hypertension (high blood pressure), anemia, unsteadiness on feet and acute kidney failure.</p> <p>The 4/4/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of three out of 15. He required partial to moderate assistance with showers, supervision with toileting, and was independent with oral hygiene and eating. He had an indwelling catheter, and was always incontinent with bowel.</p> <p>The assessment indicated the resident did not have any physical or verbal behaviors directed towards others. He did not reject care from staff. He did not wander and did not have a wander elopement guard.</p> <p>-However, record review and interviews indicated the resident did have a wander elopement guard (see below).</p> <p>B. Resident #3's family member interviews</p> <p>(continued on next page)</p>

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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>One of Resident #3's family members was interviewed on 10/10/24 at 1:48 p.m. The family member said all of the resident's family members were very involved with the care of Resident #3. She said Resident #3 was a gentle soul and did not have negative behaviors. The family member said he did wander throughout the facility looking for sunlight to sit in. The family member said a social worker approached another family member on Wednesday 5/29/24, in the afternoon, and asked if the family would consider transferring Resident #3 to a facility with a secured unit because the facility staff felt Resident #1 was exit seeking. The family member said the other family told the social worker that the family would consider transferring Resident #3 to another facility with the request that the family be allowed to tour a few secured facilities in order to choose which facility the family felt was best for their loved one.</p> <p>The family member said the conversation on 5/29/24 was the first time the facility staff had spoken with the family about possibly moving Resident #3. The family member said on Friday 5/31/24 in the afternoon, just 48 hours after the conversation about possibly transferring the resident to another facility, the family was informed Resident #3 had been transferred to a different facility.</p> <p>The family member said the family was shocked Resident #3 had been transferred and a family member left work to go to the facility to see what had happened. The family member said by the time the family member got there, Resident #3 was already gone. The family member said the other family member gathered Resident #3's belongings and headed to the new facility where Resident #3 had been transferred.</p> <p>Another family member of Resident #3 was interviewed on 10/15/24 at 3:00 p.m. The family member said the family was not afforded the privilege to look at places for Resident #3 before the facility moved him. The family member said the resident was a gentle soul and he believed the situation brought the family and the resident trauma. The family member said the new facility where Resident #3 was transferred was costing the family more money than the original facility cost. The family member said no one should live through what their family had gone through because of how Resident #3 had been transferred from the facility.</p> <p>C. Record review</p> <p>On 3/4/24 a family member signed a consent form for Resident #3 to have a wander guard placed.</p> <p>The comprehensive care plan, initiated 10/9/23, revealed Resident #3 was an elopement risk/wanderer, was disoriented to place, had a history of attempts to leave the facility unattended, had impaired safety awareness and wandered aimlessly. The resident had impaired cognitive function/dementia or impaired thought processes with dementia and wandered with no purpose. Pertinent interventions included a wander guard to alert staff to the resident's attempts to leave through the doors (initiated 5/23/24), one-to-one supervision at all times (initiated 5/24/24) and discussing concerns regarding the resident's overall status/health with the resident/family as needed (initiated 5/25/24).</p> <p>A 5/31/24 at 12:32 p.m. social services progress note revealed, the social service worker received an email from the receiving facility for Resident #3 that they were able to accept the resident.</p> <p>-However, according to family interviews (see above) and staff interviews (see below), the family was not notified until after the resident had already been transferred to the other facility.</p> <p>(continued on next page)</p>		

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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A 5/31/24 at 5:10 p.m. social service progress note revealed the former social service director (SSD), who was now one of the facility's social service assistants (SSA), left a voicemail for the family in regards to Resident #3's discharge. The progress note documented in pertinent part, (SSD) Apologized for how social services handled the discharge by not providing proper notice and the proper documentation support in the efforts of finding proper placement for (Resident #3). SSD stated that there will be reeducation and training regarding how SSA can better and appropriately handle future discharges. Furthermore, SSD outlined the reasons for discharge regarding safety concerns with wandering around the facility. SSD explained that the new facility will be safer for the resident and that they were able to accept him in a placement in (the same city). SSD accepted full responsibility of the actions of the social services team and will ensure the proper training and education is completed.</p> <p>-There was no further documentation in Resident #3's electronic medical record (EMR) regarding the resident's transfer to the new facility on 5/31/24.</p> <p>III. Staff interviews</p> <p>The DON and the corporate consultant (CC) were interviewed together on 10/14/24 at 12:15 p.m. The DON and the CC said Resident #3 was a sweet person who had a wander guard and often tried to wander out the door.</p> <p>Both the DON and the CC said the discharge for Resident #3 was not done correctly. The DON and the CC said the facility did not call the family, nor did they provide the family with other facility names to go and look at before the resident was discharged to a new facility.</p> <p>The DON and the CC said the facility cut the family out and did not tell the family about the place or let the family go visit the new place ahead of time. The DON and the CC said the facility had a breakdown in their process for discharge. The DON and the CC said since the incident happened to Resident #3, the facility management developed a better way to ensure individuals would be discharged properly. The DON and the CC said discharges were now discussed in morning meetings and, if there would be a discharge, everyone on the interdisciplinary team (IDT) team would be involved in the discharge planning.</p> <p>The SSA (who was the facility's former SSD) was interviewed on 10/15/24 at 1:00 p.m. The SSA said he was the SSD at the time of Resident #3's discharge. The SSA said he was not involved in the situation until the end of the day on 5/31/24. The SSA said the resident was exit seeking and did have a wander guard on for many months.</p> <p>The SSA said there was a lot of miscommunication between the former nursing home administrator (FNHA) and the family of Resident #3. The SSA said as soon as the FNHA got word the receiving facility approved the resident's transfer, the FNHA sent Resident #3 there immediately.</p> <p>The SSA said the family was not given notice nor was the family given any choices of places to visit for Resident #3. The SSA said the situation did not happen the way a discharge was supposed to happen. The SSA said the family was not called until late afternoon on 5/31/24, after Resident #3 had already been transferred to the new facility. The SSA said he did not write any discharge care plans or a discharge summary before or after Resident #3 was discharged .</p>		