

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 10/02/2025
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure three (#2, #11 and #12) of twelve residents were kept free from physical abuse out of twelve sample residents. Specifically, the facility failed to: -Protect Resident #2 from physical abuse by Resident #3; -Protect Resident #11 from physical abuse by Resident #3; -Protect Resident #12 from verbal abuse by Resident #3; and, -Protect Resident #12 from physical abuse by Resident #1. Findings include: I. Facility policy and procedure The Abuse, Neglect, and Exploitation policy and procedure, dated February 2023, was provided by the director of nursing (DON) on 10/2/25 at 3:50 p.m. It revealed in pertinent part, It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish, which can include staff-to-resident abuse and certain resident-to-resident altercations. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse, including abuse facilitated or enabled through the use of technology. Mental Abuse includes, but is not limited to, humiliation, harassment, threats of punishment, or deprivation. Mental abuse also includes abuse that is facilitated or caused by nursing home staff taking or using photographs or recording in any manner that would demean or humiliate a resident(s). Physical Abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking. It also includes controlling behavior through corporal punishment. Verbal Abuse means the use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability. The facility will develop and implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property; establish policies and procedures to investigate any such allegations; includes training for new and existing staff on activities that constitute abuse, neglect, exploitation, and misappropriation of resident property, reporting procedures, and dementia management, and resident abuse prevention; and establish coordination with the Quality Assurance and Performance Improvement (QAPI) program. The facility will designate an abuse prevention coordinator in the facility who is responsible for reporting allegations or suspected abuse, neglect, or exploitation to the state survey agency and other officials in accordance with state law. II. Incident of physical abuse by Resident #3 towards Resident #2 on 8/12/25A. Facility investigation The 8/12/25 facility investigation documented Resident #2 suffered</p> <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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 065267	If continuation sheet Page 1 of 6

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>was referred to psychiatry services.3. Resident interviewResident #2 was interviewed on 9/30/25 at 1:58 p.m. Resident #2 said he had incidents with Resident #3 three times. He said he thought she did it because she was delusional.Resident #2 said that Resident #3 threatened him and told him she was going to cut him into small pieces or kill him in his bathroom. Resident #2 said that he was worried about other residents because she was dangerous, and he had to place a chair behind his room door. Resident #2 said Resident #3 hit other residents in the facility, including Resident #11. Resident #2 said he reported all these incidents to the staff. III. Incident of physical abuse by Resident #3 towards Resident #11A. Resident #11 (victim)1. Resident status Resident #11, age [AGE], was admitted on [DATE]. According to the September 2025 CPO, the diagnoses included type 2 diabetes mellitus, unspecified dementia, psychotic disturbance, mood disturbance, major depressive disorder, anxiety, and heart failure.The 9/8/25 MDS assessment revealed the resident was moderately cognitively impaired with a BISM score of 11 out of 15. He required one-person assistance with transfers, bathing and toileting. 2. Record reviewThe 5/29/24 care plan documented Resident #11 exhibited cognitive loss related to altered cognitive performance and dementia. Interventions included discussion of concerns regarding overall status and health with the resident's family as needed, explaining all care before providing it to reduce resident tension and promote a comfortable experience, inviting and escorting to activity programs as desired, and reducing noise and distractions as indicated to provide a calm environment. The care plan also documented that Resident #11 was at risk for mood and behavior changes due to his mental diagnoses; he had a history of refusing care, verbal agitation, aggression, and racial comments towards the staff during care. Interventions included follow-up by for psychiatry services, observation for mental status and behavior changes when new medication started or with changes in dosage, providing time alone if he became physically aggressive, and encouraging the resident to communicate feelings.3. Resident interviewResident #11 was interviewed on 10/1/25, at 12:43 p.m. Resident #11 said Resident #3 threw water on his head a few months ago. Resident #11 said he notified the staff, but they did nothing. Resident #12 said sometimes Resident #3 spoke to him in an aggressive way.IV. Incident of physical abuse by Resident #3 towards Resident #12A. Resident #12 (victim)1. Resident statusResident #12, age [AGE], was admitted on [DATE]. According to the September 2025 CPO, the diagnoses included cerebral atherosclerosis, sequelae of cerebral infarction, and generalized anxiety disorder. The 9/2/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. He required skilled occupational therapy due to impaired range of motion for transfers, toileting and bathing. 2. Record reviewThe 7/22/25 care plan documented Resident #12 had a psychosocial wellbeing problem related to anxiety, inability to problem solve, ineffective coping, and verbal aggression. Interventions included pain assessment, consultation with pastoral care, social services, and psychological services as needed, increased communication between resident, family, and caregivers about care, living, and environment, with explanations of all procedures, treatments, medications, and changes in conditions. Interventions also included checks every 15-minutes until determined by an interdisciplinary team (IDT), behavior monitoring, redirection through conversation around preferred activities, including smoking and golf, and when conflict arises, remove the resident to a calm, safe environment and allow him to share his feelings.3. Resident interviewResident #12 was interviewed on 10/1/25, at 10:40 a.m. Resident #12 said a few months ago, Resident #3 came to his room with a note. Resident #12 said the note said Resident #3 would come to Resident #12's bedroom and would cut his penis while he sleeps. Resident #12 said he should not be threatened like that. Resident #12 said he did report it to the staff, but he did not hear back from them. He said he knew they would not do anything about it. Resident #12 was interviewed again on 10/1/25, at 4</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>p.m. Resident #12 said he knew Resident #3 was schizophrenic, but he never saw her hitting anybody else. Resident #12 said Resident #3 threatened others, but just verbally or with notes that she left in their bedrooms. He also said Resident #3 went several times to the men's bedrooms, and he was afraid of her coming to this bedroom.V. Incident of verbal abuse between Resident #12 towards Resident #10A. Resident #10 (victim)1. Resident statusResident #10, age [AGE], was admitted on [DATE]. According to the September 2025 CPO, the diagnoses included type 2 diabetes mellitus, diabetic polyneuropathy, chronic obstructive pulmonary disease (COPD), severe major depressive disorder without psychotic disturbance, post-traumatic stress disorder (PTSD), and cognitive communication deficit. The 7/9/25 MDS assessment revealed the resident was cognitively intact with a BISM score of 14 out of 15. He required one person assistance with transfers, set up assistance with hygiene, and he is independent with toileting. 1. Observations On 9/30/25, at 1:58 p.m., Resident #10 was by the nurse's station, speaking loudly. At that moment, Resident #12 yelled at Resident #10 with racial and discriminatory insults, and bad words. Resident #10 yelled back to Resident #12 using similar language. The incident was witnessed by staff members, residents, and surveyors. 2. Record reviewThe 9/30/25 social service progress note documented Resident #10 talked very loudly in the hallway, and the other resident came out of his room yelling for this resident to be quiet because he could not hear his television This resident continued to argue with Resident #10. Both residents were redirected to their rooms; no injuries were noted. The police were notified The 1/15/25 care plan documented Resident #10 was at risk for decreased psychosocial well-being and adjustment issues, emotional distress, ineffective coping skills, behavioral symptoms, poor impulse control, adverse effects on function, mental, physical, social, or spiritual well-being related to his diagnosis of depression and suicidal thoughts. Resident #10 had a loud voice, which may be perceived by others as yelling. Resident #10 was also at risk for verbal altercations with others due to this. The resident often related this to being from New York and said he was not willing to change the tone of voice as he was just being himself. Interventions included: assessment of coping strategies and respect for the resident's wishes to the extent possible, assessment of preferences and choices with activities and encouraging involvement, establish rapport using therapeutic communication, encourage to voice feelings and frustrations as indicated, observe for tearfulness, increased agitation, and decreased participation in care, observe and document changes in behavior, including frequency of occurrence and potential triggers, and document and record behavioral episodes.The care plan documented, due to his PTSD, Resident #3 had a habit of talking extremely loud which is sometimes disturbing to others as it appears he was angry, but was only loud. Interventions included: administration of medication as ordered and monitoring for side effects (notify physician if observed); assisting to normalize feelings, so the resident knew he was not alone in his thoughts, experiences, feelings, and behaviors; attempting non-pharmacological approaches as indicated to reduce fears and/or anxiety related to incidents (music therapy, breathing exercise, talking to the resident about their feelings, providing a secure and comfortable environment, meditation, aroma therapy, reading materials, and offering preferred activities; contacting resident's representative or friend for comfort and support; and behavioral and psychological services as indicated, care in pairs for this resident related to his false accusations and made up stories about others (initiated on 9/30/25).3. Resident interviewResident #10 was interviewed on 10/2/25 at 11:10 a.m. Resident #10 said that due to his PTSD, he heard noises and had flashbacks when he had arguments. Resident #10 admitted he did not get along with Resident #12, and they had previous arguments, but it did not happen very often. Resident #10 said Resident #12 was the one who usually started the arguments and spoke badly about his home country, so he had to respond because it was personal</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>for him.VI. Staff interviewsCertified nurse aide (CNA) #1 was interviewed on 10/1/25 at 11:15 a.m, CNA #1 said the staff tried to redirect Resident #3 to avoid or separate her from other residents, and report behaviors. However, CNA #1 said she did not hear about physical abuse cases with other residents. CNA #1 said the staff told Resident #10 several times he was too loud, and other residents got mad because of it. Registered nurse (RN) #3 was interviewed on 9/30/25 at 4:18 p.m. RN #3 said she was aware of the incident between Resident #2 and Resident #3. RN #3 said that most of the time, both residents had arguments, but with no physical aggression. RN #3 also said one of the problems was that Resident #3 refused to take her medication; and in order to prevent incidents, the staff did 15-minute checks when things got worse, took them to smoke at a different time, and had someone check on them. RN #3 said these interventions partially work because they both had issues with other residents. RN #3 said that she was not sure if Resident #3 had hit Resident #11 in the past because she was a relatively new employee.RN #3 said regarding the incident between Resident #10 and Resident #12, Resident #10 was really loud and Resident #12 told him to shut his mouth. RN #3 said and the argument started with personal insults. RN #3 said she saw something like this in the past.RN #3 said Resident #10 insulted several people, and was always loud, and he got mad if a staff member tried to redirect him.Licensed practical nurse (LPN) #3 was interviewed on 10/1/25 at 1:04 p.m. LPN #3 said she was aware of the incident between Resident #2 and Resident #3. LPN # 3 said after the incident, the staff separated them, reported to the abuse coordinator, interviewed the residents to find out what happened and how they felt, and started 15-minute checks.The social services director (SSD) was interviewed on 10/1/25 at 4:25 p.m. The SSD said Resident #3 refused medication and treatment, could get loud, and talked about men in a negative way. The SSD said Resident #3 was referred to psychiatric services.The DON was interviewed on 9/30/25 at 2:04 p.m. She said she was responsible for NHA duties in the absence of NHA and she was an abuse coordinator in the building at the moment. She said she was aware of Resident #3 passing notes to residents and staff with threatening messages. She said the notes were part of Resident #3's behavior. She said Resident #3 was not dangerous and her notes were disregarded since they were not a danger to other residents. The NHA said the facility did not investigate every note Resident #3 wrote.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for one (#7) of five residents reviewed for quality of care out of 12 sample residents. Specifically, the facility failed to change a wound care dressing daily for Resident #7, per the physician's order. Findings include: I. Resident #7A. Resident status Resident #7, age less than 65, was admitted on [DATE]. According to the October 2025 computerized physician orders (CPO), diagnoses included vascular dementia (cognitive decline due to damaged blood vessels to the brain), type 2 diabetes, diabetic neuropathy (damaged nerves due to diabetes), atrial fibrillation (abnormal heart rhythm) and hemiplegia (paralysis of one side of the body) following a stroke (brain cell death due to interrupted blood flow to the brain). The 8/4/25 minimum data set (MDS) assessment identified Resident #7 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The assessment documented Resident #7 required substantial/maximal assistance from staff for toileting hygiene, dressing, and transfers and showering. B. Resident interview and observation Resident #7 was interviewed on 10/1/25 at 11:50 a.m. Resident #7 said the nursing staff did not change her wound dressing. The resident pointed to a wound dressing on her left calf. Her left calf was wrapped in kerlix gauze and had tape on top of the gauze, which was dated 9/28/25 with a smiley face on it. C. Wound care observations On 10/1/25 at 1:40 p.m. the assistant director of nursing (ADON) and licensed practical nurse (LPN) #2 changed Resident #7's dressing. They washed their hands prior to putting gloves on. Resident #7's left middle calf still had the kerlix gauze wrapped around the calf with tape on top of the gauze dated 9/28/25 and signed with a smiley face, indicating the dressing was last changed on 9/28/25. The ADON removed the old dressing from the resident's wound. The resident's calf wound had a general red appearance and had some beefy red open areas, approximately quarter-sized with well defined borders. There were a few other quarter-sized scabbed areas LPN #2 said the resident's wound was overall healing. LPN #2 sprayed wound cleanser on the wound and patted it dry. She added calcium alginate (wound treatment), an abdominal pad (ABD - a large thick padded dressing) pad, wrapped the resident's calf with kerlix gauze and dated and signed the new dressing with a smiley face on top. D. Record review Review of Resident #7's October 2025 CPO revealed the following physician's order: For venous wound on left shin - clean with wound cleanser (a solution to remove contaminants) and pat dry, add calcium alginate (an antimicrobial, moist-healing wound dressing) and ABD to the wound, wrap with kerlix gauze every day shift, ordered 9/18/25 at 6:00 a.m.-However, observations on 10/1/25 revealed Resident #7's left calf dressing had not been changed since 9/28/25, three days prior (see observation above). II. Staff interviews Wound care physician (WCP) #1 was interviewed on 10/1/25 at 1:55 p.m. WCP #1 said Resident #7 had a venous ulcer due to her chronic conditions, including a lack of circulation to her legs, a lack of mobility and her increased age. WCP #1 said the current wound care order for Resident #7's calf wound was to change the left calf dressing daily. WCP #1 said she expected the nursing staff to change the wound dressing daily if she or the wound care nurse were not at the facility to change the dressing. The director of nursing (DON) was interviewed on 10/1/25 at approximately 3:30 p.m. The DON said she did not know why Resident #7's left calf dressing was not changed as scheduled. She said the nursing staff should follow the physician's wound care orders.</p>		