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	12/04/2025

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 0600 Level of Harm - Minimal harm or potential for 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. (continued on next page)

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

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on 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 procedureThe 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 investigationThe 8/12/25 facility investigation documented Resident #2 suffered physical abuse when Resident #3 hit Resident #2 on his cheek and pulled his beard when both residents came back into the building from the smoking patio. Staff members witnessed the incident and separated the residents immediately. Resident #2 was assessed by a charge nurse and did not experience any pain or injury.The incident was reported to the police, the residents' families, the physician, the ombudsman, and adult protective services. Both residents were placed on frequent checks, and an investigation started. Resident #2 did not experience any fear following the incident and did not know why he was hit. Resident #3 denied knowing the reason for the contact and could not recall the incident. B. Resident #3 (assailant)1. Resident statusResident #3, age [AGE], was admitted on [DATE]. According to the September 2025 computerized physician orders (CPO), the diagnoses included type 2 diabetes mellitus and schizophrenia (mental disorder). The 7/18/25 minimum data set (MDS) assessment revealed the resident was cognitively impaired with a brief interview for mental status (BIMS) score of nine out of 15. She was independent with toileting, and required set up assistance for transfers. 2. Record reviewThe behavior care plan, dated 1/28/25, documented Resident #3 had behavioral symptoms, including delusions and hallucinations. Resident #3 also had a history of refusal of care, sexual statements, odd statements, outbursts of thoughts, and yelling at other residents. The care plan documented most behaviors were directed towards males. Resident #3 refused consent to receive psychiatric services and said that she deals with her problems by journaling or being outside. Resident #3 also had a history of making false accusations. Interventions included activities assessment for diversional activities; encourage the resident to write in her journal when she appeared to be

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on 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 statusResident #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 observationResident #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 observationsOn 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.