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	03/23/2023

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43950 Based on interviews and record review, the facility failed to ensure one (#1) of two residents reviewed for accidents out of four sample residents received adequate supervision to prevent an accident/hazard. Resident #1, who had a diagnosis of medically complex conditions, was admitted to the facility on [DATE]. The facility failed to follow standards of practice in providing incontinence care by not having all supplies ready and letting go of the resident after rolling her to her side. The facility failed to timely implement appropriate interventions, including assistance with all activities of daily living (ADL) as documented in her significant change 11/17/22 minimum data set (MDS) assessment. The facility failed to provide and implement two person bed mobility/toileting assistance and failed to consistently provide two person bed mobility/toileting assistance after the fall according to record review, interviews and in accordance with the resident's care plan. Due to the facility's failures, and the staff's failure to take proper and reasonable care when providing bed mobility/toileting assistance resulted in a fall from the bed that resulted in the resident sustaining injuries of a right and left femur (thigh) fractures, a right head laceration requiring seven staples, and required hospitalization for three days. Findings include: I. Facility policy and procedure The Falls Practice Guide policy, dated December 2011, was provided by the nursing home administrator (NHA) on 3/23/23 at 3:50 p.m. It read in pertinent part, The purpose of the Falls Practice Guide is to describe the process steps for identification of patient fall risk factors and interventions and systems that may be used to manage falls. Comprehensive care plan: Based upon the findings of the MDS (minimum data set) and CAAs (care area assessment) and following review of risk factors, environmental factors and other clinical conditions, the patient's initial care plan is updated or a comprehensive care plan is developed to include individualized patient interventions that focus on the patient's risk factors. II. Resident status (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 0689 Level of Harm - Actual harm Residents Affected - Few	Resident #1, age 89, was admitted initially on 1/29/19, and readmitted on [DATE]. According to the March 2023 computerized physician orders (CPO), diagnoses included left femur fracture, right femur fracture, muscle weakness, and anxiety disorder. The significant change 11/17/22 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. She required extensive assistance with two persons physical assistance for bed mobility, dressing, toilet use, bathing and personal hygiene. Transfers did not occur over the entire seven day period. There were no behavioral symptoms or rejection of care. The significant change 1/25/23 minimum data set (MDS) assessment revealed the resident was cognitively intact with a BIMS score of 14 out of 15. She required extensive assistance with two persons physical assistance for bed mobility, transfers, dressing, toilet use, bathing and personal hygiene. There were no behavioral symptoms or rejection of care. The resident was always incontinent of bowel and bladder. III. Resident interview Resident #1 was interviewed on 3/21/23 at 11:39 a.m. She said certified nurse aide (CNA) #1 was going to change her and she rolled her to the side. Resident #1 said she was in a position that made her slip out of the bed and she fell to the wood floor. Resident #1 said she was in a state of shock and the police came and helped to calm her on the floor. Resident #1 said she was moved from the floor and put on a stretcher; she felt shocked, scared and stunned. Resident #1 said she felt numb at first and she did not feel like screaming when it happened. Resident #1 said she started feeling the pain on the way to the hospital. Resident #1 said now she had two people to change her, before the fall she had one person help with bed mobility. Resident #1 said her legs hurt now if she moved them and there was a large black scab on the top/back of her head. Resident #1 said there were certain places on her body that were still tender and she still had a fear of falling. IV. Record review Care plan: Review of the ADL care plan established prior to the 1/17/23 fall revealed that it had not been developed to include two persons physical assistance for bed mobility, dressing, toilet use, bathing and personal hygiene although the 11/17/22 MDS had been coded as requiring such care, which was the highest level of care needed during the seven day period. The ADL care plan was updated after the 1/17/23 fall and added two assist with bed mobility, toileting, daily hygiene, dressing, date initiated 2/13/23. -The resident had returned to the facility on [DATE], after her hospitalization . The care plan was not updated and revised to include two person assistance with bed mobility until 2/13/23, 28 days after the resident's fall on 1/17/23. Review of the urinary incontinence care plan revealed it was updated and added after the 1/17/23 fall two person assist during incontinence care date initiated 1/19/23. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #1's medical record (EMR) revealed the following progress notes documented in pertinent part: 1/17/23 at 2:45 p.m., Registered nurse (RN) assessment: This nurse was called to resident's room by staff nurse stating resident had fallen out of bed while being changed by certified nursing aide (CNA). Upon entering the room noted resident laying on the floor faced down with a towel under her face. Bleeding noted from gash on the right side of resident's head. Had a small skin tear to right shoulder. Resident was able to state her name and state she was in pain and wanted to get off the floor. Another RN obtaining vital signs at this time. Clear area around resident for safety. While RN applied gauze to gash in head for pressure this nurse, head neck in alignment with assistance of CNA to turn resident over. Upon turning resident over noted a skin tear to resident right knee and right foot. Resident was still alert and oriented upon assessment. EMS (emergency medical services) arrives to take over. Fall protocol in place. 1/17/23 at 3:31 p.m., CNA was turning resident and rolled her over and let go for just a second and she rolled off the bed. The bed was in the high position. Resident was laying on her right side on her stomach. Called RN #1 and RN #2 to come assist. Call to 911 was placed and paramedics with (name) came at once. This writer called the daughter of resident and left her message of what was happening with her mother. Call and message was also left with RN at (provider) to inform medical doctor (MD) #1 and nurse practitioner (NP) #1. Resident received a laceration to right side of her (head) also scraped her knees and tore scabs off as well off her toes. She also had marks to her upper back and mid back on right side. Paramedics here and took at 3:25 p.m. 1/17/23 at 3:39 p.m., This RN responded to resident's reported fall while LPN (licensed practical nurse) called 911. Resident observed to be lying on the floor with a bleeding laceration to her head. The resident and CNA both reported that the resident fell while being turned in bed. Initial assessment showed that resident's vital signs were within her baseline limits (pulse 85, O2 (oxygen saturation) 90, BP (blood pressure) 143/93). A/O (alert and oriented) x4. Resident reported 10/10 pain, generalized, on her buttocks, and on her head. Tenderness to palpation in bilateral pelvic area. PERRLA (pupils equal, round, reactive to light and accommodation). Resident had a laceration to the right side of her head. Scabs on bilateral knees and toes opened during the fall and were bleeding. New small open area on buttocks resulting from the fall. Abrasions on the right shoulder and mid-back were also observed. EMT's arrived and took over resident care and transfer. 1/18/23 at 10:06 a.m.,IDT (interdisciplinary team) met to review fall from bed yesterday, remains in hospital. Was sent to hospital and remains there. Will review when returns. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	1/19/23 at 1:17 p.m., Resident readmitted to the facility from community hospital via stretcher with (name) at 11:15 a.m. following post fall with diagnosis of bilateral femur fractures. Medication regimen reviewed with physician assistant (PA) #1, no issues found. Resident was A & O (alert and oriented) x3 (person, place and time), able to make her needs known. Resident was on a regular diet, regular texture, poor appetite, and eats meals by herself with a setup tray. Incontinence with bowel and bladder. Resident was on 2 L (liters) O2 (oxygen) via NC (nasal cannula). Dressing was changed on the bilateral lower leg today as per a report given by hospital RN. Resident had bruises on the back of bilateral hands and right forearm from the IV (intravenous) site. Resident was admitted to hospice at the hospital. Hospice admission nurse was in the building today to see the resident. Resident denies any pain at this time, states she was only in pain when her leg was moved. The resident had a new order for PRN (as needed) oxycodone. NP from optum informed about readmission and new order. Daughter updated about patient's condition and new order. Call light placed within reach. Bed was in the lowest position. V/S (vital signs) 120/54, 97.5, 63, 92% on 2L O2 via NC. 1/20/23 at 10:38 a.m., Update: Patient was sent out to hospital on 1/17/23 status post (s/p) fall with increased pain and laceration to right side of head. Pt was admitted to hospital where she was diagnosed with bilateral femur fractures. Pt was admitted to hospice services for end of life care. Patient readmitted to this facility on 1/19/23. Upon admission, per nursing note, patient with seven staples on right side of her scalp with crusted blood/OTA (open to air), bruise on back of both hands and RFA (right forearm) from IV site. Recent weight not available. Continue diet per order. Will restart supplements. 1/21/23 at 1:06 p.m., Resident continues on charting for readmission s/p fall. Resident had seven staples to head that are clean, dry and intact.Resident's bed in low position and requires the assistance of two persons to assist with changing. Resident had not complained of any pain or discomfort related to fall. Hospital records: The 1/17/23 emergency room physician note revealed in pertinent part, Reason for consult: Fall at nursing home. History of present illness: Resident #1 is an [AGE] year old female presenting with traumatic injuries sustained after falling at a skilled nursing facility. She was sent to the ED by medical transport for evaluation with her advanced directive documents and medication list. She was found to have bilateral distal femur fractures on plain film. Trauma surgery consultation was requested. Resident #1 was unable to provide history due to advanced dementia and was moaning in pain. Physical exam: Elderly female moaning in pain. Laceration right parietal (near the top of head) region. The 1/18/23 hospitalist progress note revealed in pertinent part, Assessment and Plan: This is an [AGE] year old female with a history of chronic lymphedema with chronic venous stasis ulcerations and wounds presenting to the emergency department after a fall during transfer resulting in bilateral distal femoral fractures. Toe abrasion; closed head injury; mechanical fall-laceration clean, dry, repaired in ED (emergency department), trauma surgery following. Mental status: She was disoriented. Psychiatric: comments: Moaning in pain. Review of the bed mobility task support provided for the past 30 days documentation revealed the following: -2/22/23 at 5:02 p.m. one person physical assistance was provided. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-2/22/23 at 10:08 p.m. one person physical assistance was provided. -2/24/23 at 1:51 p.m. one person physical assistance was provided. -2/25/23 at 1:59 p.m. one person physical assistance was provided. -2/26/23 at 1:59 p.m. one person physical assistance was provided. -2/27/23 at 1:24 p.m. one person physical assistance was provided. -3/1/23 at 1:59 p.m. one person physical assistance was provided. -3/5/23 at 1:09 a.m. one person physical assistance was provided. -3/5/23 at 1:40 p.m. one person physical assistance was provided. -3/6/23 at 5:53 a.m. one person physical assistance was provided. -3/6/23 at 4:45 p.m. one person physical assistance was provided. -3/8/23 at 1:59 p.m. on person physical assistance was provided. -3/9/23 at 1:36 p.m. one person physical assistance was provided. -3/10/23 at 6:45 p.m. one person physical assistance was provided. -3/13/23 at 12:42 a.m. one person physical assistance was provided. -3/13/23 at 1:59 p.m. one person physical assistance was provided. -3/17/23 at 1:59 p.m. one person physical assistance was provided. -3/18/23 at 2:41 p.m. one person physical assistance was provided. -3/22/23 at 2:38 a.m. one person physical assistance was provided. -3/23/23 at 4:15 a.m. one person physical assistance was provided. -Although the newly revised care plan read, two assist with bed mobility updated after Resident #1's fall, the staff continued to provide one person assistance, placing Resident #1 at a continued risk of another fall. Review of the toileting task support provided for the past 30 days documentation revealed the following. -2/20/23 at 5:16 p.m. one person physical assistance was provided. -2/22/23 at 8:17 p.m. one person physical assistance was provided. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-2/24/23 at 6:28 p.m. one person physical assistance was provided. -3/3/23 at 11:40 a.m. one person physical assistance was provided. -3/5/23 at 1:18 a.m. one person physical assistance was provided. -3/9/23 at 1:36 p.m. one person physical assistance was provided. -3/10/23 at 11:37 p.m. one person physical assistance was provided. -3/18/23 at 2:59 a.m. one person physical assistance was provided. -3/18/23 at 1:26 p.m. one person physical assistance was provided. -3/18/23 at 2:42 p.m. one person physical assistance was provided. -Although the newly revised care plan read, two person assist during incontinence care updated after Resident #1's fall, the staff continued to provide one person assistance, placing Resident #1 at a continued risk of another fall. V. Facility's investigation of Resident #1's fall The post fall investigation noted, Incident report: date of incident 1/17/23 at 3:00 p.m. Location: resident's room. Description of incident: CNA #1 was turning to change her and she rolled her over too far and she fell off the bed which was in the high position. Describe care provided to the patient following incident: CNA #1 was turning the resident and rolled her over and let her go for just a second and she rolled off the bed. The bed was in a high position. Resident was laying on her right side on her stomach. RN #1 and RN #2 were called to come assist. Call to 911 was placed and paramedics came at once. The resident's daughter was called and a message was left of what was happening with her mother. Call and message the physician. Resident received a laceration to the right side of head, scraped her knees and tore scabs off her toes. She had marks on her upper back and mid back on right side. Paramedics arrived and took at 3:25 p.m. Patient was taken to the hospital 1/17/23 at 3:35 p.m. Summary of alleged incident: CNA #1 was turning resident to change her, and she rolled her over too far and she fell off the bed which was in the high position. Disposition by NHA: After a thorough investigation, neglect was unsubstantiated. It was determined that the CNA followed the patient's care plan/task list related to ADL cares. Employee (CNA #1) was brought back from suspension. Patient returned from the hospital on 1/19/23 with bilateral fractures to the femur. Care plan was reviewed and updated to two-person assistance related to bed positioning/mobility and ADL cares due to change in resident condition. Education was initiated with CNAs related to positioning, fall prevention and reviewing tasks lists prior to caring for a patient. An audit was put into place to monitor the position of patients when providing cares and monitoring correct transfer status. This will be monitored weekly for 4 weeks. Statements: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident #1 on 1/19/23 at 11:30 a.m. I have never felt abused or neglected by CNA #1. I am absolutely certain, I love that gal. It wasn't her fault. She's one of my best friends. I know how to report abuse or neglect. Multiple residents interviewed and all had no problems with CNA #1. CNA #1 on 1/17/23 and 1/18/23 (time not documented), the person conducting the interview was the NHA. Around 2:20 pm I went to the room to perform vitals. At this time, she (Resident #1) requested to be changed. I started cares. She (Resident #1) was rolled onto her left side, per patient request and care plan. I let go of the patient to turn to grab her brief on the side of me, at this time the patient started to roll off the bed. I tried to catch her but was unsuccessful. I immediately notified my nurse for assistance. Multiple staff members interviewed and all had no problems with CNA #1. RN #2 on 1/30/23 (time not documented), LPN #1 notified her of the fall. She instructed LPN #1 to call 911 while RN #1 and she assessed and stabilized the resident. VI. Staff interviews The NHA was interviewed on 3/23/23 at 2:00 p.m. She said CNA #1 was not suspended until 1/20/23 (the fall occurred 1/17/23) as they were not aware of the extent of Resident #1's injuries until later and as they got into the investigation for the fall it was determined there could be a suspicion of neglect so that was when they suspended her for three days (1/20/23, 1/21/23, and 1/22/23). The NHA said she was the abuse coordinator, but it was collaborative with the IDT. The NHA said after the fall they met as a team and put in three corrective plans-staff education, a skills fair with hand on return demonstration, and monitoring/auditing. The NHA said she addressed having the MDS assessment match the care plan to make sure it matched the required assistance levels. She said the team was monitoring staff to see if they were transferring according to the kardex (brief overview of individual patient care). The NHA said prior to the fall the MDS assessment did not match the care plan and the kardex but that was how she wanted it completed now. The NHA said if the MDS assessment said a resident needed two person assistance then it needed to be two person assistance on the care plan. The NHA said a CNA could not change how much assistance a resident needs. She said if the kardex said the resident needed two person assistance then that's what should be given. The NHA said it was important for CNAs to document correctly the level of assistance given to a resident in order to follow the proper transfer status, and important for safety of the patient and staff. The NHA said she would start immediate education on proper documentation and monitoring of incontinence care and bed mobility since it was brought to her attention, during the survey, that currently CNAs were documenting one person assistance with bed mobility and incontinence care on residents who required two person assistance including Resident #1. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	CNA #1 was interviewed on 3/23/23 at 2:39 p.m. She said she went to change Resident #1 and she was rolled to her side, and when she got the brief, Resident #1 fell off the bed. CNA #1 said Resident #1 was panicky and upset and thought she was going to die. CNA #1 said Resident #1 was in a lot of pain when the paramedics picked her up, she was crying, moaning in pain and scared. CNA #1 said the bed was too high, her mattress was too small in width, and Resident #2 should have been a two person assist with bed mobility and incontinence care. CNA #1 said her usual incontinence care techniques were to get everything ready, roll the resident over, clean them, and put on a new brief. CNA #1 said she failed to have all of her supplies ready and she just got herself out of order and she let go of the resident and just was not thinking. CNA #1 said mainly Resident #1 should have been a two person assistance. RN #2 was interviewed on 3/23/23 at 2:50 p.m. She said she was the facility's infection preventionist and nurse educator. She said since Resident #1's fall she had been conducting audits related to transfers (but not specifically to bed mobility and toileting). RN #2 said the questions on the audit read, Did staff follow the care plan related to transfers? Residents positioned safely in bed during and after transfer? Staff able to verbalize the correct transfer status and position? RN #2 said the audits came after Resident #1's fall and was designed to capture bed mobility and transfer status. RN #2 said she was now doing the audit one time per month. RN #2 said since it was brought to her attention, during the survey, that staff were not following the care plan related to bed mobility and incontinence care and were documenting one person assistance with bed mobility and incontinence care on residents who required two person assistance including Resident #1, she would now rewrite the audit and redo the education. The MDS coordinator (MDS #1) and director of nursing (DON) were interviewed on 3/23/23 at 12:48 p.m. MDS #1 said she did a quarterly MDS assessment every three months, and annual MDS assessment (every 365 days). MDS #1 said if there was a significant change MDS assessment then that was a new starting date and it included a full assessment. MDS #1 said the full MDS assessments trigger the care plan to be updated and different departments contribute to the care plan. MDS #1 said she did the ADL, continence and falls sections of the assessment. MDS #1 said she decided what went to the kardex and she hand made the kardex from the care plan. MDS #1 said Resident #1's 11/17/22 MDS assessment was the last full assessment before the fall on 1/17/23 and that was the MDS assessment her care plan came from. MDS #1 said the 11/17/22 MDS assessment read that Resident #1's bed mobility was extensive assistance with two persons but that was not what she had put on the care plan, but with the audits she would start doing that now. MDS #1 said she would now put residents who required two person assistance on the MDS assessment with two person assistance on the care plan. MDS #1 said before the fall if the MDS assessment said the resident required two person assistance she would not put that on the care plan. MDS #1 said she had put down care in pairs on the care plan for Resident #1. MDS #1 said she did not put it on the care plan prior because a resident often would need one person assistance usually with occasional two persons assistance. MDS #1 and the DON said that Resident #1 should have two person assistance at all times for bed mobility and incontinence care, it was now on the resident's care plan and on the kardex. The MDS #1 and DON said it was important to follow for the resident's safety and health. MDS #1 and the DON said they would find out which CNAs were not providing two person assistance and write them up, since it was brought to their attention during the survey, that currently CNAs were documenting one person assistance with bed mobility and incontinence care on residents who required two person assistance including Resident #1. MDS #1 and the DON said it was important to have accurate documentation for best resident care and safety. (continued on next page)

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