STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065382	A. BUILDING _____ B. WING _____	**03/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BROOKDALE SKYLINE	**2365 PATRIOT HTS COLORADO SPRINGS, CO 80904**

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 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure services were provided to one (#1) out of three sample residents who met professional standards of quality. Specifically, the facility failed to ensure an assessment of Resident #1 was completed by a registered nurse (RN) following an unwitnessed fall. Findings include: I. Facility policy and procedure The Falls Management policy and procedure, revised July 2018, was provided by the director of nursing (DON) on [DATE]20 at 8:55 a.m. It revealed, in pertinent part, A fall refers to unintentionally coming to rest on the ground, floor, or other lower level of either witnessed or unwitnessed, with or without injury. When a fall occurs: assist the patient and provide first aid, notify the charge nurse and assess for injuries . II. Resident #1 Resident #1, [AGE], was admitted on [DATE]. According to the February 2020 computerized physician orders [REDACTED]. The 2/3/2020 minimum data set (MDS) assessment revealed the resident had moderate impairment with a brief interview for mental status score (BI[CONDITION]) of 11 out of 15. She required extensive assistance of one person with activities of daily living. It indicated the resident did not sustain any falls prior to the resident's admission to the facility. III. Record review The fall risk care plan, initiated on 1/28/2020, revealed the resident was at risk for falls. The interventions included: ensure the resident ' s call light was within reach, encourage the resident to wear appropriate footwear when ambulating or mobilizing in a wheelchair, provide resident a safe environment and evaluate and treat by physical/occupational therapy as ordered. The [DATE]20 change of condition evaluation revealed the resident sustained [REDACTED]. The Resident's wheelchair was in the bedroom and the walker was nearby the resident. The resident did not use call light. Assessed resident for injury, no abnormalities or deformities noted to extremities. No skin alterations noted. The resident denies pain at this time. The resident was asked if she hit her head and her speech was unclear but the nurse understood yes. There were no marks to the resident back of the head, however, a hematoma could form. Vital signs were with normal limits, a neurological assessment started, and the physician and family were notified. The change of condition assessment was completed by a licensed practical nurse (LPN) #1. The resident's medical record was reviewed on [DATE]20 at 4:57 p.m. It did not reveal documentation by a registered nurse (RN) assessment following an unwitnessed fall on [DATE]20 at 5:00 a.m. IV. Staff interviews The RN #1 was interviewed on [DATE]20 at 5:25 a.m. She said she was not aware of the Resident #1 fall on [DATE]20 at 5:00 a.m., and she did not assess the resident after unwitnessed fall with a possible head injury. The LPN#1 was unavailable for an interview. The director of nursing (DON) was interviewed on [DATE]20 at 9:00 a.m. She said an RN assessment should be completed after a resident sustained [REDACTED]. She said the assessment was not within a LPNs scope of practice, and all nursing staff would be educated as soon as possible.

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