STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065376	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookdale Greenwood Village	6450 S Boston St Greenwood Village, CO 80111

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** Based on record review and interviews, the facility failed to ensure residents had adequate supervision and assistive devices to prevent accidents for one (#28) of three residents reviewed out of 34 sample residents. Specifically, the facility failed to ensure supervision was provided, as determined in an assessment, to prevent a fall for Resident #28 that resulted in fractures. Resident #28 was admitted on [DATE] with diagnoses of sepsis (infection of the blood), unsteadiness on feet, generalized muscle weakness, repeated falls and other Alzheimer's disease.Resident #28, was identified as a fall risk and had a history of repeated falls. Resident #28 was found outside by facility staff on 3/29/26. Resident #28 was bleeding from her mouth and had pain when trying to bend her knees. Resident #28 was sent to the emergency department, where it was determined that Resident #28 had sustained a fracture to her coccyx and facial bones. Resident #28 did not return to the facility. Findings include:I. Facility policy and procedureThe Falls Management policy, March 2026, was provided by the nursing home administrator (NHA) on 4/13/26 at 11:07 a.m. It read in pertinent part, Residents should be evaluated for the risk of falling so that interventions may be considered in order to promote resident safety, promote appropriate clinical and interdisciplinary (IDT) assessment of falls and fall risk factors, and coordinate management of acute and recurrent falls. Fall risk data collection should be completed at admission, the evaluation may include: history of falls, cognitive status/behavior symptoms, vision status, continence, mobility, balance, vital signs, age, health conditions/risk factors, and medications. If the resident fall score is equal to or above 10, they should be considered a high risk for falls. The IDT should implement a fall prevention plan to assist with reducing falls related to risk factors and history of falls. Initial interventions may include, but are not limited to room set up, reviewing the resident's balance, footwear review, lighting, call system orientation, personal items within reach.II. Resident #28A. Resident statusResident #28, age [AGE], was admitted on [DATE] and was discharged to the hospital on 3/29/26. According to the March 2026 computerized physician's orders (CPO), diagnoses included sepsis, unsteadiness on feet, generalized muscle weakness, repeated falls and other Alzheimer's disease.The 3/25/26 minimum data set (MDS) assessment revealed Resident #28 had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 12 out of 15. Resident #28 required the use of a walker when ambulating and required substantial to maximal assistance with toilet transfers and partial to moderate assistance with walking 50 feet. The assessment documented walking on uneven surfaces was not attempted due to medical conditions and going up and down a curb was not attempted. The MDS assessment indicated Resident #28 had at least one fall with no injury in the last two to six months prior to admission.B. Facility investigation of Resident #28's fall on 3/29/26Review of the facility's investigation of Resident #28's fall on 3/29/26 revealed the NHA interviewed multiple staff members between the dates 3/30/26 and 4/3/26. The investigation documented registered nurse (RN) #3 was interviewed. RN #3 said he was outside of the building and found Resident #28. He said he was planning on checking on her anyway because she had communicated with him that she was going outside. He said it was about 6:30 p.m. He said when he found her, she was lying on her back, (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	holding a newspaper. He said she was fully clothed and had her shoes on. He said, during his assessment, he noticed she was bleeding from her mouth. He said she had told him she tripped while she was walking and landed on her face. He said he saw Resident #28's walker close to the sidewalk nearby. RN #3 said he asked qualified medication administration person (QMAP) #1 to go get RN #4 from the second floor. He said when he attempted to get Resident #28 to sit up, she complained of pain. He said he had her remain in the lying position and did not note any other scrapes, cuts, or bruises other than the bleeding from her mouth. He said he stayed with Resident #28 until RN #4 and emergency services arrived. He said he then went upstairs to start transfer paperwork. The investigation documented RN #4 said QMAP #1 had notified her of the situation. RN #4 said she immediately responded to the location and took over from RN #3. She said she did a head to toe assessment and asked Resident #28 if she could move her legs. Resident #28 said she could not move her legs due to pain. Resident #28 told her she had hit her head and RN #4 noted Resident #28 was bleeding from her mouth. RN #4 said that she and RN #3 stayed with Resident #28 until emergency services arrived. She said she stayed with Resident #28 when emergency services took over. She said when Resident #28 left in the ambulance she went back upstairs to help with notifications and paperwork. She said the last time she saw Resident #28 before she fell was at medication pass at about 6:00 p.m. The investigation documented licensed practical nurse (LPN) #5 was interviewed. LPN #5 said she was not involved in the situation, but RN #4 had told her about the fall. She said the last time that she had seen Resident #28 was about 5:30 p.m. She said she had been sitting in a chair near the nurses' station. She said she had seen Resident #28 go outside at times during the day and she would come back up with no issues. She said she had only done that a few times.The investigation documented certified nurse aide (CNA) #4 was interviewed. CNA #4 said she had last seen Resident #28 sitting in a chair at the nurse's station around 6:30 p.m. or 6:45 p.m.The investigation documented QMAP #1 (who worked in the assisted living residence on the same campus as the skilled nursing facility) was interviewed. QMAP #1 said a family member came to the assisted living residence door and told him about Resident #28 outside. He said he ran outside and saw that RN #3 was already out there with Resident #28. He said RN #3 told him to run and get RN #4. He said after he got RN #4, he stayed outside until emergency services arrived, then went back to his building. -None of the above interviews had a date or time documented on them that indicated when they were conducted. The investigation documented the NHA interviewed the director of rehabilitation on 3/31/26. The interview documented the director of rehabilitation said Resident #28 required stand-by assistance to contact guard assistance for transfers, depending on how tired she was. She said she was walking with a four wheel walker and ambulating 200 feet prior to the fall. She said Resident #28 was safe to ambulate alone. She said Resident #28 was safe to go outside alone and sit near the patio table but not much further than the table. She said as long as Resident #28 stayed in that area, she would be fine. -However, review of physical therapy notes revealed Resident #28 was not independent with ambulation and was not safe to ambulate alone outside (see record review below). An interview with the director of rehabilitation revealed Resident #28 was not independent with ambulation or safe to ambulate outside independently (see staff interviews below). The facility investigation included an IDT post event analysis. The analysis revealed Resident #28 went outside unaccompanied and was found on her back on the ground in the parking lot. The analysis documented Resident #28 said she went for a walk and fell. The resident reported she hurt all over. The analysis documented she was not using an assistive device at the time of the fall, and contributing factors to the fall was she was unaccompanied outside. The analysis documented Resident #28 was on frequent checks at the time of the fall and had one to two falls in the past 90 days. The analysis documented Resident #28 ambulated with no problems with the use of a device. C. Record reviewThe resident at risk for falls care plan, initiated 3/21/26, indicated that Resident #28 was at risk for falling. Pertinent interventions included placing the call light within reach and encouraging Resident #28 to use the call light, placing a call don't fall sign in the resident's room, encouraging proper footwear when (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	ambulating, placing floor mats on either side of the bed when Resident #28 was in bed, completing frequent checks, providing frequent toileting, placing the bed in lowest position, and providing cueing/supervision/assistance as indicated. The special instructions listed at the top of the care plan indicated Resident #28 was at risk for falls. -However, neither the care plan or special instructions indicated how much supervision Resident #28 required when ambulating. A review of Resident #28's electronic medical record (EMR) revealed the following:A nursing admission note, dated 3/20/26 at 11:48 p.m., documented Resident #28 arrived at the facility in a wheelchair and was alert and oriented by two or three at admission. Resident #28 was admitted to the skilled facility after a urinary tract infection (UTI) and sepsis. A comprehensive nursing note, dated 3/21/26 at 8:56 p.m., documented Resident #28 required skilled observation and assessment. The note documented Resident #28 needed one-person assistance with her activities of daily living (ADL). The functional assessment, dated 3/21/26 at 11:10 a.m., documented Resident #28 used a front wheel walker and was a contact guard assist (a level of assistance where a caregiver or therapist maintains physical contact with a resident to provide stability and safety during tasks) with walking on level surfaces and was dependent on staff when walking on uneven surfaces. The note documented the plan of treatment was to work on gait training to normalize gait pattern and facilitation of swing through. The note documented therapeutic activities to work on gross motor coordination, transfer training to increase functional task performance and bed mobility activities to increase functional skills. A comprehensive nursing note, dated 3/23/26 at 10:11 p.m., documented Resident #28 was working with physical therapy (PT) and occupational therapy (OT) for strengthening. The note documented Resident #28 used a wheelchair for her mobility. A comprehensive nursing note, dated 3/24/26 at 10:42 p.m., documented Resident #28 was on frequent room checks due to getting up unassisted, walking with her walker unassisted or holding on to furniture to walk. The note documented Resident #28 was reeducated multiple times on calling for staff assistance with transfers. Resident #28 needed frequent reminders that staff needed to be with her to walk. The physical therapy note, dated 3/24/26 at 11:44 a.m., documented Resident #28 participated in gait training and was able to walk 100 feet with a front wheel walker and contact guard assist for safety. The note documented Resident #28 required verbal cueing to maintain focus on the task, posture and step placement. The note documented Resident #28 also participated in physical therapy, focusing on transfer training. The note documented Resident #28 worked on transfers from the wheelchair using her front wheel walker with contact guard assist. She performed toilet transfers with minimal assistance and constant cueing. The note documented Resident #28 demonstrated impulsive transfer behavior despite maximal verbal cues and physical cues. A social services progress note, dated 3/25/26 at 11:46 a.m., documented Resident #28 required contact guard assist for all of her mobility. The noted documented Resident #28 walked 125 feet with a front wheel walker with a contact guard assist. The physical therapy note, dated 3/29/26 at 6:17 p.m., documented Resident #28 worked on gait training throughout the facility with stand-by assist. Resident #28 performed gait training with head turns, obstacle navigation, change in gait speed to facilitate dynamic standing balance (ability to maintain stability while moving or shifting weight in an upright position) to reduce the risk of falling. The note documented Resident #28 participated in seated therapy exercises to facilitate lower extremity strength to help improve low functional activity tolerance for community distance gait training. -Review of the physical therapy notes did not reveal Resident #28 was able to ambulate safely independently or was able to ambulate independently outside on uneven surfaces. Am eInteract SBAR (situation, assessment, background, recommendation) note, dated 3/29/26 at 7:21 p.m., documented a change in condition of a fall for Resident #28. The note documented she was sent to the emergency department. A nursing progress note, dated 3/29/26 at 7:21 p.m., documented staff notified the RN that a resident was found on the ground outside. The RN responded immediately and requested assistance from another RN for further assessment. Upon assessment, Resident #28 was noted to be lying on her back with both legs extended towards the north and her head towards the south. Blood was observed coming from her (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	mouth. The resident stated she had hit her head. Emergency services were notified. A nursing progress note, dated 3/30/26 at 6:25 a.m., documented Resident #28 was found outside of the facility approximately 30 feet to the left of the front door. Resident #28 was fully clothed and had shoes on and had a newspaper in her hand. The note documented her mouth was bloody and no teeth were noted to have been broken. The note documented no abrasions, cuts or bruises were visible. When the RN asked Resident #28 to sit up, Resident #28 complained of back pain. The RN asked for Resident #28 to stay in place and called 911. A hospital progress note, dated 3/31/26 at 3:14 p.m., documented Resident #28 was admitted to the hospital on [DATE] due to a fall. The progress note documented the results of a computed tomography (CT) scan for Resident #28 as loosening of AD 9-11 (upper left central incisor #9, upper left lateral incisor #10, and upper left canine #11) with fractures of the anterior walls of those sockets. The CT scan also documented a closed fracture of the coccyx. III. Staff interviewsCNA #1 was interviewed on 4/8/26 at 10:56 a.m. CNA #1 said Resident #28 had been admitted to the facility prior to her most recent admission on [DATE]. She said Resident #28 was able to walk, but needed assistance. She said there were times when Resident #28 had to use the wheelchair when she was really tired or had lots of pain. She said there were times when she was resistant to care due to pain. She said she could not remember if she was a fall risk, but she said she needed assistance from one person. She said Resident #28 was not supposed to walk alone outside. She said Resident #28 needed assistance. LPN #3 was interviewed on 4/8/26 at 11:08 a.m. LPN #3 said Resident #28 was a one- to two-person assist when she first came to the facility. She said she was a one-person assist when she ambulated with her walker. She said she never saw Resident #28 go outside. She said Resident #28 was not supposed to go outside unattended. She said she had heard that Resident #28 had gone outside and fell. She said she heard it happened during shift change, which may have been how she had gotten outside. CNA #1 was interviewed a second time on 4/8/26 at 1:26 p.m. CNA #1 said she received information regarding the residents from the shift report and also by looking at the special instructions in the computer system. She said the special instructions did not always indicate if a resident was a fall risk or what kind of assistance the residents required. CNA #6 was interviewed on 4/9/26 at 5:46 a.m. CNA #6 said he was informed if a resident was a fall risk during shift change and the nurses would also communicate with him. He said sometimes when a resident was admitted from the hospital, he would see their fall risk wristband on the resident's wrist. He said interventions that the facility always had for fall risk residents were low bed and fall mats. LPN #4 was interviewed on 4/9/26 at 6:41 a.m. LPN #4 said Resident #28 was not independent and was not to go outside alone. She said she was a one-person assist when ambulating. Emergency medical services was interviewed on 4/9/26 at 9:08 a.m. He said they received the call regarding Resident #28 on 3/29/26 at 7:22 p.m.RN #4 was interviewed on 4/9/26 at 9:15 a.m. RN #4 said she started her shift on 3/29/26 at 5:30 p.m. She said at the start of her shift she got report and then did medication pass at 6:00 p.m. She said when she went to give Resident #28 her medications, she remembered seeing Resident #28's visitor leaving with her small dog. She said a little bit later, QMAP #1 came up to get her saying that another RN was asking for her help. She said she went downstairs and outside and saw that Resident #28 was lying on her back. She said she saw blood coming from her mouth. She said when she touched the resident, she screamed in pain. She said when she asked her to move her feet, the resident screamed out in pain. She said RN #3 called 911 from his phone and she ran back upstairs to grab some paperwork and when she had come back, the emergency services were already there. She said that evening was the first time she had worked with Resident #28. The director of rehabilitation was interviewed on 4/9/26 at 10:33 a.m. The director of rehabilitation said physical therapy completed assessments on all of the new residents who came in for rehabilitation. She said that the therapy team used a facility form called therapy to nursing forms to communicate fall interventions, how a resident transferred, ambulated, and if the resident used any assistive devices. She said if a resident had a fall, the fall was discussed during the morning meeting. She said if there were any new interventions or orders, nursing staff would implement the interventions and put (continued on next page)

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