

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065240	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/20/2026
NAME OF PROVIDER OR SUPPLIER Brighton Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2025 E Egbert St Brighton, CO 80601	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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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 one (#1) of three residents reviewed for accidents out of three sample residents remained as free from accidents and hazards as possible. Resident #1, who had diagnoses of cerebral palsy (a movement disorder caused by brain damage during infancy), dorsalgia (back pain), adult failure to thrive, scoliosis (spine posture abnormality), dysphagia and osteoporosis, was admitted to the facility on [DATE]. Resident #1 was dependent on staff for transfers utilizing a Hoyer lift (mechanical lift). On 6/19/26 at 1:00 p.m. registered nurse (RN) #1 and certified nurse aide (CNA) #1 were transferring Resident #1 from her wheelchair to bed using the Hoyer power lift 700 using a large, full body sling. During the transfer, the staff heard a popping sound and the sling attached to the Hoyer lift's sling bar (a bar that did not have a safety latch but had a curled bar that was supposed to prevent the sling from slipping) came undone. Resident #1 fell onto the floor and hit her head on the floor. The resident experienced increased pain, sustained a forehead hematoma (a closed wound where blood collects after an injury causing pain and swelling), and a forearm bruise and was sent to the emergency room (ER) for further evaluation. The resident was diagnosed with a traumatic head injury. Resident #1 reported the incident caused her increased anxiety and she had increased pain to her head and forearm after the accident. Specifically, the facility failed to ensure Resident #1 was transferred safely using the Hoyer lift. Findings include: Record review, observations and interviews confirmed the facility corrected the deficient practice related to Resident #1's fall, including removing the two Hoyer 700 lift from use, prior to the onsite investigation on 7/20/26, which resulted in the deficiency being cited as past non-compliance with a correction date of 6/26/26. I. Incident on 6/19/26 On 6/19/26 at 1:00 p.m. RN #1 and CNA #1 were transferring Resident #1 using the Hoyer lift. During the transfer, one of the sling loops came unhooked and the resident fell to the ground, striking her head. Resident #1 was transferred to the hospital and diagnosed with a head injury. II. Facility plan of correction A. Immediate action to correct the deficient practice Resident #1 was transferred to the hospital for evaluation and treatment. An interview was completed with the resident when she returned and her care plan was updated. B. Identification of other residents The nursing home administrator (NHA), the director of nursing (DON) and the regional clinical resource reviewed and audited the care plans and assessments of all residents who required assistance with transferring via mechanical lifts. There were 14 residents who were dependent on staff for transfers and required the use of a mechanical lift out of a census of 83. C. Systemic changes On 6/23/26 RN #1, who was hired on 4/30/26, received counseling and education regarding appropriate Hoyer lift transfers. The counseling included following policy on all transfers and lifts to ensure the correct sling size was used at all times. On 6/23/26 CNA #1, who was hired on 5/19/26, received counseling and education regarding appropriate Hoyer lift (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 065240 If continuation sheet Page 1 of 8

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F 0689 Level of Harm - Actual harm Residents Affected - Few	transfers. The counseling included following policy on all transfers and lifts to ensure the correct sling size was used at all times. The counseling also included to not be rushed, and to ensure the sling loops were securely latched. All nursing staff were re-educated on proper mechanical lift procedures, including appropriate sling sizes, and double checking the mechanical lift and the sling were secure before transfer. Also ensuring all sling loops were secured in place to the machine and did not slide off prior to transfer and provided a return demonstration of knowledge by 6/26/26. D. Monitoring The DON/designee would conduct three random Hoyer lift transfer audits per week via observation to ensure proper transfers were conducted and that staff were competent to perform the transfers. Audits would be documented via excel spreadsheet and reviewed monthly in the quality assurance and program improvement (QAPI) meeting for a minimum of 12 weeks or until substantial compliance had been achieved. The last QAPI meeting was 7/15/26. III. Facility policy and procedure The Activities of Daily Living (ADL), Lifting and Movement of Residents policy and procedure, revised 1/12/26, was provided by the NHA on 7/20/26 at 12:40 p.m. It read in pertinent part, In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents. Resident safety, dignity, comfort, and medical condition will be incorporated into goals and decisions regarding the safe lifting and moving of residents. Staff responsible for direct resident care will be trained in the use of manual (gait/transfer belts, lateral boards) and mechanical lifting devices. Mechanical lifting devices shall be used for heavy lifting, including lifting and moving residents when necessary. Only staff with documented training on the safe use and care of the machines and equipment used in this facility will be allowed to lift or move residents. Mechanical lifts are only to be operated with two staff members during transfers. Staff will be observed for competency in using mechanical lifts and observed periodically for adherence to policies and procedures regarding use of equipment and safe lifting techniques. Enough slings, in the sizes required by residents in need, will be available at all times. Maintenance staff shall perform routine checks and maintenance of equipment used for lifting to ensure that it remains in good working order. All equipment design and use will meet or exceed guidelines and regulations concerning resident safety and the use of restraints. Continually evaluates the effectiveness of workplace safety and injury-prevention strategies. IV. Manufacturer recommendations The user instruction manual for the Hoyer power lift 700 mechanical lift, dated 2024, was provided by the NHA on 7/20/26 at 5:33 p.m. It read in pertinent part, Read and understand the user instruction manual before using the Hoyer power lift 700. Slings: the Hoyer HPL700 has a six-point bari loop spreader bar. The six-point system uses slings with webbing loops which allow positioning adjustment by selecting different colored straps. Loop strap slings: Hoyer bari quickfit and bari full back slings. The six-point system attaches to the spreader bar hooks via loop straps. Each sling is supplied with instructions. Please study the instruction guide before use. Warning: Hoyer recommends the use of genuine Hoyer parts. Hoyer slings and lifts are not designed to be interchangeable with other manufacturer's products. Using other manufacturer's products on Hoyer products is potentially unsafe and could result in serious injury to patient and/or caregiver. Do not lift a patient unless you are trained and competent to do so. Always carry out the daily check list located towards the end of the manual before using the lift. Always fit the sling according to the instructions provided (user instructions). Always carry out lifting operations according to the instructions in the user manual. V. Resident #1A. Resident status Resident #1, age greater than 65, was admitted on [DATE] and readmitted on [DATE]. According to the July 2026 computerized physician orders (CPO), diagnoses included cerebral palsy, dorsalgia, adult failure to thrive, scoliosis, dysphagia and osteoporosis. The 5/8/26 minimum data set (MDS) assessment revealed the resident's short and long (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	term memory were okay per staff assessment. The resident was normally able to recall the current season, location of own room, staff names and faces, and that she was in a nursing home. She was dependent on staff assistance for eating, oral hygiene, toileting hygiene, shower/bathing, upper/lower body dressing, personal hygiene, rolling left and right, chair to bed-to-chair transfers and shower transfers. She was dependent on staff assistance for mobility with a manual wheelchair. The MDS assessment revealed the resident was not on a scheduled pain regimen and did not receive as needed (PRN) pain medication. The assessment revealed the resident experienced pain rarely or not at all and rarely or not at all interfered with sleep, therapy activities, or day to day activities. The assessment revealed the resident's worst verbal descriptor of pain was mild. B. Resident and resident representative interview Resident #1 was interviewed on 7/20/26 at 10:00 a.m. Resident #1 said she had a fall recently from the Hoyer lift and it made her feel anxious. Resident #1 said RN #1 was there and helped her after the fall. She said the other staff member, CNA #1, no longer worked at the facility. Resident #1 said the staff made a mistake in transferring her and CNA #1 did not hook up the strap correctly and went too fast. Resident #1 said CNA #1 was on her left side and that was the side that she fell from. Resident #1 said it was not a safe transfer. She said CNA #1 did not check the sling straps and the strap fell off on the left side. Resident #1 said after the fall, she was on the floor and she had pain in her arm, hit her head and had a headache for a few weeks. The resident's representative was interviewed on 7/20/26 at 2:30 p.m. The resident's representative said Resident #1 told her that during the Hoyer lift transfer on 6/19/26, CNA #1 was trying to rush. She said CNA #1 did not secure the top part of the Hoyer lift sling by hooking up the strap securely and the sling tipped and Resident #1 went down on her head. The resident's representative said Resident #1 had made complaints to her before about CNA #1, saying that he was always in such a hurry. The resident's representative said Resident #1 would try to tell CNA #1 something and he would just walk out. The resident's representative said she had talked to the DON. She said the DON assured the representative that she would have instructional classes and staff education after this incident. The resident's representative said Resident #1 had always been fearful of being dropped and she was always a little fearful of things, such as falling out of bed, so the fall from the Hoyer lift really increased her fear. The resident's representative said Resident #1 started taking a new antidepressant medication recently in July 2026 to help decrease her anxiety. The resident's representative said when Resident #1 first fell, she had a lump and knot on her head and her forehead was black and blue. The resident's representative said Resident #1 could have broken a bone when she fell. She said the incident worried her a lot. She said the resident also sustained a bruise on her arm during the fall. The resident's representative said she was uneasy about the caregiver, CNA #1, and when the facility first called her about the accident, the facility said the resident was very stiff. She said it made it seem like the facility was placing blame on Resident #1. The resident's representative said the main point was that Resident #1 needed gentle hands, especially because of her diagnoses and fears. C. Facility investigation The facility investigation was provided by the NHA on 7/20/26 at 10:50 a.m. The investigation revealed Resident #1 had fallen from the Hoyer lift while RN #1 and CNA #1 were transferring her from her wheelchair to her bed. The investigation documented neurological checks were at baseline, no changes in mentation were noted at that time and a hematoma was noted by the nurse to the resident's left forehead and a bruise was noted to the resident's left forearm. The resident was sent to the ER for further evaluation. The resident returned to the facility on 6/19/26. The investigation documented that while Resident #1 was at the hospital, a computed tomography (CT-imaging) scan of the head and neck was completed for indication of trauma and pain. The findings of CT scan revealed mild to moderate left frontal scalp soft tissue swelling. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	There was no skull fracture or acute brain hemorrhage. The findings of the CT scan of the spine revealed no acute fractures. The hospital after visit summary, dated 6/19/26, documented a diagnosis of a fall with a traumatic injury of the head. The facility identified a concern regarding the Hoyer lift transfer incident with Resident #1. It was identified that the Hoyer lift did not have safety latches but had a curled bar that was supposed to prevent the sling from slipping. The Hoyer lift and sling were inspected and removed from use. There were no noted rips or tears to the sling utilized. The Hoyer lift was in working condition. Education was provided to staff on choosing the right sling for the right task. The DON audited all residents who utilized a Hoyer lift for transfers, to ensure their slings were in good condition and appropriate size for the resident. The NHA ordered all new Hoyer slings for each resident. The slings were labeled with the residents' last name and first initial, and each resident received two slings. The DON provided education to staff, from 6/19/26 to 6/26/26, who used a Hoyer lift to ensure they were competent with the use of the Hoyer lift. In addition, competencies were conducted with a return demonstration to ensure the staff members were competent with the transfers. They were also instructed on observing the Hoyer lift sling prior to application. The DON assessed all Hoyer lift slings for appropriate size and condition to ensure there were no slings that were frayed or in poor condition. The DON updated all physician's orders for residents who required Hoyer lift transfers with any changes to sling size that may need to be made to include which Hoyer lift to utilize for the resident. All care plans were reviewed, and changes were made as necessary. The appropriate size of sling and Hoyer lift size was added to the residents' electronic medical records (EMR) and Kardex (staff directive tool) for easy access of reference for staff. The investigation documented Resident #1 was interviewed on 6/22/26 by the social services director (SSD). The SSD asked Resident #1 if she knew what happened or why she fell from the Hoyer lift on 6/19/26. Resident #1 responded that she did not know, but she thought it broke; it was so fast and then she was on the floor. The investigation documented RN #1 was interviewed on 6/19/26 by the SSD. RN #1 said she assisted CNA #1 with Resident #1's transfer using the Hoyer lift. RN #1 said that she was at the back of the resident's chair and CNA #1 was on the left side of the chair. The lift sling was in place and the resident was lifted up with the lift toward the bed. RN #1 heard a pop and one side of the sling gave way and Resident #1 fell toward the side that gave way. RN #1 said CNA #1 attempted to grab Resident #1 as she fell. RN #1 said CNA #1 was able to hold onto her and both the CNA #1 and Resident #1 went to the floor over the top of the legs of the lift. RN #1 said Resident #1 did bump her head on the ground. RN #1 said she completed a full body assessment, she had contractures and stiffness with minimal movement at baseline, and Resident #1 said her head was hurting, but no other pain. RN #1 said she initiated neurological checks and notified nurse management. The investigation documented CNA #1 was interviewed, undated, by the SSD. CNA #1 said he was getting ready to put Resident #1 in bed after lunch because she liked to go to bed after lunch. CNA #1 said he got Resident #1 in the sling in her chair. CNA #1 said he then asked RN #1 to come and help him with the Hoyer lift. CNA #1 said RN #1 was in the back and he was in the front and they turned Resident #1's body together. CNA #1 said he heard a pop and saw Resident #1 falling and he went straight under her with his knees and arms to try to prevent her from hitting her body on the ground. CNA #1 said he saw Resident #1 bump her head on the floor and to his knowledge, her head was the only thing that hit the ground. CNA #1 said after Resident #1 was checked out, they proceeded to put Resident #1 back into the bed using a different sling. The investigation documented the root cause of the fall was either due to not having a safety latch on the bar or a particular sling. The team removed all the Hoyer 700 lifts from use and were looking at purchasing additional Hoyer lifts with a safety latch on the bar where the slings attached. The maintenance resource was looking (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	7/16/26 a new physician's order was initiated for Sertraline HCl (hydrochloride) oral tablet 50 mg. Give one tablet by mouth one time a day for anxiety. The 7/20/26 social services note revealed the SSD checked in with Resident #1 related to her psychosocial status. The SSD checked in on how Resident #1 was feeling about Hoyer lift transfers and the resident stated she had no concerns. Resident #1 had recently started on Sertraline due to anxiety and she reported she did have anxiety at times, but was doing okay despite that. The 7/20/26 fall committee IDT follow-up note revealed the team removed all the Hoyer 700 lifts from use and would look at purchasing additional Hoyer's with a safety latch on the bar where the slings attached. The maintenance resource was looking into manufacturer's logs to determine if the root cause of Resident #1's fall was due to not having a safety latch on the bar or a particular sling. VI. Staff interviews RN #1 was interviewed on 7/20/26 at 1:05 p.m. RN #1 said Resident #1 fell to the left side during the Hoyer lift transfer on 6/19/26 that was completed with CNA #1. RN #1 said the Hoyer lift was lifting Resident #1 up. She said CNA #1 was moving the base of the lift and turned the lift towards the bed. RN #1 said there was a popping sound and Resident #1 went down to the ground. RN #1 said CNA #1 partially caught Resident #1, but they both went down to the ground together. RN #1 said Resident #1 hit her left forehead and left forearm on the ground. RN #1 said they were using a large sized full-body sling, but that sling did not seem to be the right one for Resident #1. She said the sling was labeled with a different person's name. RN #1 said she got a different medium sized sling to put Resident #1 back to bed but that one also seemed to want to slip off of the Hoyer lift and the type of sling was also not correct for her. RN #1 said the new plan was to keep the residents' slings in their rooms with their names on the slings. RN #1 said because of the way Resident #1 leaned, it seemed like the sling they used for the transfer was not right for her. She said it was a large size sling and the resident should have had a medium size and a different type of sling. RN #1 said the pop she heard was the lift sling loop coming out of the metal curled bar on the lift. RN #1 said the Hoyer 700 lift they used did not have safety latches. RN #1 said she had a concern because the Hoyer 700 lift was the only one with the capability of weighing the residents. RN #1 said the fall incident with Resident #1 occurred because the lift sling strap just slipped off on CNA #1's side. RN #1 said Resident #1 had a headache right after she fell. The NHA and the regional clinical resource were interviewed together on 7/20/26 at 4:05 p.m. The regional clinical resource said on 6/19/26, CNA #1 had Resident #1 in the sling and fastened on the Hoyer lift before RN #1 arrived to assist with the transfer. The regional clinical resource said RN #1 was the operator of the lift controls and CNA #1 was guiding Resident #1 when they heard a popping sound and Resident #1 started to fall. The regional clinical resource said CNA #1 tried to help hold Resident #1, but fell with the resident to the floor. The regional clinical resource said RN #1 did the assessment of the resident and started neurological checks and sent the resident out to the ER. The regional clinical resource said they checked the sling and the Hoyer 700 lift was pulled from the floor because the sling fell off the lift. The NHA said the Hoyer 600 lifts had safety latches, so they were still in use and there had been no other falls from Hoyer lifts and none prior to at least back to March 2026 when she first started as the NHA. The regional clinical resource said Resident #1 went from a full-body type of sling to a U-shaped sling which was better for her body type. The regional clinical resource said that all of the facility's slings were intact, but the Hoyer lift manufacturer wanted them to use a particular sling and only genuine Hoyer parts and slings (called Hoyer bari quickfit and bari full-back slings) and they said they were not designed to be interchangeable with other manufacturer's products. The regional clinical resource said the Hoyer 700 lift still did not come with the safety latches and that was a concern to her. The regional clinical resource said the root cause of Resident #1's fall was the loop/straps of the lift sling slipped off the bar due to the lift having no safety latches and the (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065240	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/20/2026
NAME OF PROVIDER OR SUPPLIER Brighton Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2025 E Egbert St Brighton, CO 80601	
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	intervention was to remove the Hoyer 700 lifts from the floor. The regional clinical resource said the Hoyer 700 lifts did not use safety latches but a curled bar that was supposed to prevent the sling from slipping, but only if staff were using a particular sling. The regional clinical resource said the facility was still researching and looking into that but meanwhile, the Hoyer 700 lifts were not on the floor. The regional clinical resource said initially in the investigation, she noticed the trend of the sling loop slipping so that was addressed in the facility's plan of correction. The regional clinical resource said the DON/designee completed staff training for Hoyer lift transfers with return demonstrations and completed a plan of correction after Resident #1's fall on 6//19/26. The NHA said the facility completed maintenance checks of the Hoyer lifts monthly and recorded them in their computer system. She said in addition, a service company came and did inspections of the Hoyer lifts. The NHA said the type of Hoyer lift that Resident #1 used when she fell was a Hoyer HPL700 lift and the sling was a large full-body sling. The NHA said RN #1 and CNA #1 both received one-on-one education and training regarding a safe and appropriate Hoyer lift transfer. The NHA said the training included to watch the sling straps for slipping off and to ensure the Hoyer lift sling loops were properly secured before proceeding with the transfer. The NHA said the nurse and CNA training included a return demonstration of knowledge and also choosing the proper sling type and size. The NHA said there were new physician's orders in place for the proper sling size and type and every resident now had two slings. The NHA said the facility was now auditing three staff members a week via observation to ensure proper technique was used for the transfers. The NHA said that the facility's last QAPI meeting was on 7/15/26 where they discussed the mechanical lift malfunction and slings, and reviewed the plan of correction and monitoring. The NHA and the regional clinical resource said Resident #1 went through times where she had anxiety because she was very dependent on staff for assistance. The NHA and regional clinical resource said Resident #1 had been taking lorazepam for anxiety since March 2026 but psychopharmacology had added Sertaline in July 2026 for anxiety.		