

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065361	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2026
NAME OF PROVIDER OR SUPPLIER Brookside Inn		STREET ADDRESS, CITY, STATE, ZIP CODE 1297 S Perry St Castle Rock, CO 80104	

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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure an environment free from risk of accidents and hazards for three (#106, #37 and #10) of six residents reviewed for accident hazards out of 42 sample residents. Specifically, the facility failed to: -Ensure Resident #106 was transported appropriately in the facility transportation vehicle, which resulted in a fall from the resident's wheelchair causing fractures to both of her lower extremities; -Ensure Resident #37's care planned fall interventions were consistently implemented by staff in order to prevent multiple falls for the resident, including one with major injury; and, -Ensure the interdisciplinary team (IDT) reviewed Resident #37 and Resident #10's falls in a timely manner in order to determine if the residents' fall interventions were appropriate or if new fall interventions were needed. Resident #106, who was admitted to the facility on [DATE], had impairments to both lower extremities, used a wheelchair for mobility and was dependent on staff assistance for transfers. On 1/30/26 Resident #106 was being transported in her wheelchair, without the foot pedals attached, in a facility transportation vehicle to an outside appointment when her upper body began sliding forward in her wheelchair. When the facility transportation driver pulled over on the side of the road, Resident #106 slid further forward in her wheelchair and struck her lower legs on a structure in the transportation van, resulting in fractures to both of the resident's tibias (the larger of the two bones in the lower leg, connecting the knee to the ankle). The facility's failure to prevent an accident on a facility transportation vehicle resulted in serious harm to Resident #106 and continued to place residents at risk for serious harm or death if not corrected immediately. Additionally, Resident #37, who was admitted to the facility on [DATE], was determined by the facility to be at high risk for falls. Between 5/27/25 and 3/7/26, Resident #37 sustained 16 falls, with the fall on 3/7/26 resulting in a laceration to the resident's right cheek which required transport to the hospital's emergency department where the resident was diagnosed with a maxillary sinus fracture (involves broken bones in the upper jaw/cheek area). The facility implemented fall interventions for Resident #37's falls, however, the interventions were not consistently implemented in a timely manner and observations during the survey revealed care planned fall interventions were not being consistently implemented by staff. Additionally, the facility failed to identify and document fall interventions in a timely manner for Resident #10, who sustained five falls between 9/25/25 and 2/11/26.</p> <p>Findings include:</p> <p>I. Immediate Jeopardy</p> <p>A. Situation of immediate jeopardy</p> <p>On 1/30/26, Resident #106 was being transported in her wheelchair, without the foot pedals attached, in a facility transportation vehicle to an outside appointment when her upper body began sliding (continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>he had been trained on, since the training had not been documented. She said that the van driver and the central supply coordinator were the only van drivers for the facility and if they had questions, they could contact the DON or the assistant director of nursing (ADON), however neither the DON or ADON had been trained on transportation. The NHA said she was unable to find any of the training that the central supply coordinator might have received prior to training the current van driver. The NHA said after the accident involving Resident #106, the van driver admitted he did not use the seatbelt as intended, but the NHA said she did not complete any investigation into the misuse of the seatbelt.</p> <p>The MTD was interviewed on 3/11/26 at 3:12 p.m. The MTD said he had been working at the facility since January 2025 as a maintenance assistant and was promoted to the maintenance director in November 2025. He said that he completed the monthly checks of the van with a specific checklist but the checklist was not specific to the van itself, but only to a medical transport vehicle. The MTD said he did not get any training specific to the van and he said he was not sure if there was an operations manual in the van's glove box. He said he never received any competencies as far as training for the van. The MTD said if the van driver had an emergency related to simple mechanics of the van, such as oil changes or flat tires, he (the MTD) could assist with that, but he said things that were more complicated and specific to the van, he was not trained to assist with.</p> <p>IV. Failed to ensure falls were reviewed by IDT timely and staff were consistently implementing care planned fall interventions to prevent a fall with major injury for Resident #37</p> <p>A. Resident #37</p> <p>1. Resident status</p> <p>Resident #37, age greater than 85, was admitted on [DATE]. According to the March 2026 CPO, diagnoses included vascular dementia, muscle wasting and atrophy, difficulty in walking, fracture of nasal bones and laceration of right cheek and temporomandibular area (area around the temple and cheek of the face).</p> <p>The 3/10/26 MDS assessment revealed the resident was severely cognitively impaired with a BIMS score of five out of 15. The resident required partial to maximal assistance from staff for most activities of daily living (ADL).</p> <p>2. Record review</p> <p>The fall care plan, revised 12/10/25, revealed Resident #37 was at risk for falls due to his history of falls, diagnoses of vascular dementia, chronic respiratory failure, hearing loss, weakness, decreased mobility, psychotropic medication use and bowel and bladder incontinence. Pertinent interventions included assisting Resident #37 to the bathroom after each meal (initiated 8/29/25 and again on 12/20/25), assisting the resident to the bathroom before meals (initiated 2/21/26), using a non-recording video monitor in the resident's room (initiated 9/13/25), prompting the resident to void every two hours while awake (initiated 9/3/25), offering assistance with transfers to furniture in the common area (initiated 1/29/26), and using a fall mat at the resident's bedside for safety (initiated 3/9/26).</p> <p>A fall risk evaluation, completed 4/26/25, revealed Resident #37 was at a high risk for falls.</p> <p>A fall risk evaluation, completed 11/9/25, revealed Resident #37 was at a high risk for falls. (continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065361	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2026
NAME OF PROVIDER OR SUPPLIER Brookside Inn		STREET ADDRESS, CITY, STATE, ZIP CODE 1297 S Perry St Castle Rock, CO 80104	
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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>An IDT note, dated 5/27/25 at 3:21 p.m., revealed Resident #37 was reviewed by the IDT team after an unwitnessed fall on 5/26/25. Resident #37 was attempting to self-transfer to the bathroom and fell due to gait imbalance, weakness and poor safety awareness. New interventions included a bedside floor mat while in bed, and prompted voiding before bed.</p> <p>An IDT note, dated 8/29/25 at 12:21 p.m., revealed Resident #37 was reviewed by the IDT team after an unwitnessed fall on 8/26/25. Resident #37 had a skin tear to his left inner thumb and first digit. Resident #37 had poor safety awareness, was often forgetful and did not utilize his call light, and attempted to ambulate independently to the bathroom. New interventions included staff assisting Resident #37 to the bathroom after meals and an occupational therapy evaluation.</p> <p>An IDT note, dated 9/9/25 at 10:28 a.m., revealed Resident #37 was reviewed by the IDT team after an unwitnessed fall on 9/5/25. Resident #37 had an abrasion to his right lateral leg. Predisposing factors included not utilizing his call light, weakness, impaired memory, poor safety awareness, confusion, and ambulating without assistance. New interventions included moving Resident #37's room closer to staff and an occupational therapy evaluation.</p> <p>-However, an occupational therapy evaluation was recommended as an intervention after the resident's previous fall on 8/26/25 (see above).</p> <p>An IDT note, dated 9/9/25 at 11:12 a.m., revealed Resident #37 was reviewed by the IDT team after an unwitnessed fall on 9/6/25. Resident #37 sustained a contusion to the back of his head with two puncture wounds. Resident #37 had poor safety awareness and did not comply with the occupational therapy recommendations or utilize his call light for assistance. Resident #37 believed he was safe to transfer himself and lost his balance, resulting in a ground-level fall. Resident #37 had been taken to the bathroom [ROOM NUMBER] minutes prior to the fall but said he was trying to go to the bathroom.</p> <p>An IDT note, dated 10/6/25 at 3:12 p.m., revealed Resident #37 was reviewed by the IDT team after a witnessed fall on 10/3/25. Resident #37 was in his room with a CNA who was placing a coffee cup on his table. Resident #37 wanted to be handed the coffee cup and attempted to stand, resulting in a ground-level fall. Resident #37 was impulsive and forgetful of his limitations. New interventions included ensuring Resident #37 was completely transferred into bed prior to finishing ADL tasks to prevent Resident #37 from standing up or transferring by himself.</p> <p>An IDT note, dated 11/10/25 at 12:03 p.m., revealed Resident #37 was reviewed by the IDT team after an unwitnessed fall on 11/9/25. Resident #37 had poor safety awareness and continued to try to get up without assistance from his wheelchair. Resident #37 had poor balance, gait and strength resulting in a ground-level fall. New interventions included a pharmacy review for Resident #37 as he was on multiple stool softeners which may have increased his need to use the bathroom.</p> <p>An IDT note, dated 12/19/25 at 1:58 p.m., revealed Resident #37 was reviewed by the IDT team after an unwitnessed fall on 12/15/25. Resident #37 was in the common area and had po</p>		