STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065382	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 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. (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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure supervision and monitor assistive devices to prevent accidents for one (#2) of five residents reviewed for accidents out of seven sample residents. The facility failed to ensure staff transferred Resident #2 appropriately with a mechanical lift which resulted in a fall with major injury for the resident.Resident #2 was admitted to the facility for rehabilitation services on 10/7/25. The resident's care plan directed staff to utilize a mechanical lift (a sit to stand lift) for transfers. On 10/11/25 certified nurse aide (CNA) #1 and CNA #2 used a gait belt (a belt that fastens around the waist, used for someone with mobility issues) to transfer Resident #2 from the toilet to her wheelchair. Resident #2 stood, and then lost the ability to bear weight in one of her legs and fell to the floor.Immediately after the incident, Resident #2 complained of right knee pain. The pain worsened and the resident was transported to the hospital on [DATE] where it was revealed that the resident had sustained a fracture to her right femur. Resident #2 discharged from the hospital and returned to the facility on [DATE].The facility investigation after the incident revealed CNA #1 and CNA #2 attempted to transfer Resident #2 using a gait belt instead of the mechanical lift.Due to the facility's failure to adequately supervise and use a mechanical lift, Resident #2 fell and sustained a fracture to her right femur. Findings include:Record review, observations and interviews confirmed the facility corrected the deficient practice related to Resident #2's fall prior to the onsite investigation on 10/27/25 to 10/28/25. The deficiency was cited as past non-compliance with a correction date of 10/17/25.I. Incident on 10/11/25The nursing home administrator (NHA) provided an investigation on 10/27/25 at 4:31 p.m. regarding Resident #2's fall incident on 10/11/25 while being transferred by CNA #1 and CNA #2. The investigation documented that on 10/11/25 Resident #2 sustained a fall while being transferred from the toilet to the wheelchair. It documented Resident #2 was sent to the hospital on [DATE] after an Xray was done at the facility for Resident #2's report of increased right knee pain. The hospital found Resident #2's injury included a fracture of the right femur.The investigation included a statement by CNA #1 on 10/13/25. It documented CNA #1 said the night before the incident, Resident #2 had complained of discomfort with use of the mechanical lift. It documented on the night of the incident, CNA #1 said she and CNA #2 used the mechanical lift to transfer the resident from the bed to wheelchair, but then used a gait belt to assist the resident onto the toilet. The statement documented when the resident stood up from the toilet, she began to fall and CNA #1 and CNA #2 assisted Resident #2 to the floor. It documented Resident #2's leg was bent when it reached the floor.-The statement revealed CNA #1 and CNA #2 had transferred the resident without the use of the mechanical lift.The investigation included a statement by CNA #2 on 10/14/25. It documented CNA #2 said she was in orientation and in training, She said CNA #1 was training her. It documented CNA #1 was apprehensive to use the mechanical lift due to Resident #2's discomfort with previous use of the mechanical lift. The statement documented CNA #2 suggested they use a gait belt for a two person transfer. It documented CNA #1 and CNA #2 proceeded with transferring the resident using the gait belt. It documented when the resident stood from the toilet she began to fall and her right leg bent inward while being assisted to the ground.The investigation included a statement by licensed practical nurse (LPN) #1 on 10/14 25. It documented CNA #1 notified LPN #1 that Resident #2 had fallen in her bathroom. It documented LPN #1 found Resident #2 on the floor in the bathroom with a gait belt on. The statement documented CNA #1 told LPN #1 that she was upset because she should have used the mechanical lift for the transfer. The investigation documented nine interviews with residents at the facility and revealed no concerns with transfer assistance.The investigation documented that Resident #2's fall resulted in a right femur fracture.II. Facility plan of correctionA. Immediate action to correct the deficient practice for Resident #2The facility provided documentation of staff education completed after the incident which included the following:A document titled Safe Patient Transfers and Kardex (staff directive tool) inservice, documented as an in person inservice provided by CNA #4 on 10/16/25. The document included 26 CNA, six LPN and four registered nurse (RN) signatures. The document included resident transfer education was reviewed during the meeting. It also included the importance of not transferring the resident without knowing their care plan status (not relying on information provided by others verbally), notification of the nurse if any concerns with transferring a resident including if the resident required reassessment and following the care plan regardless of the type of transfer the therapist was working on with a resident.A document titled Use of Therapy to Nursing Communication Form, dated 10/17/25, documented the director of rehabilitation services (DOR)