STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065379	A. Building B. Wing	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Adara Living	12975 Sheridan Blvd Broomfield, CO 80020

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure two (#4 and #2) of three residents reviewed for abuse were kept free from sexual abuse out of five sample residents. Specifically, the facility failed to: -Protect Resident #4 from sexual abuse by Resident #3; and, -Protect Resident #2 from sexual abuse by Resident #3. Findings include: I. Facility policy and procedure The Abuse policy, dated 1/30/25, was provided by the nursing home administrator (NHA) on 6/23/25 at 4:00 p.m. It read in pertinent part, It is the policy of this facility to maintain an environment free of abuse and neglect. The resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion. Identifying physical or psychosocial indicators of abuse (including injuries from an unknown source), neglect, exploitation, and misappropriation of resident property from situations of verbal, mental, sexual or physical abuse. The distribution of staff on each shift in sufficient numbers to meet the needs of the residents and assure that staff assigned have the knowledge of individual care needs. In cases of abuse, the quality assurance committee will review the circumstances of the abuse to determine if changes in policies and procedures are necessary to provide further preventative measures. II. Incident of sexual abuse towards Resident #4 by Resident #3 on 5/2/25 A. Facility investigation The 5/2/25 facility investigation was provided by the NHA on 6/23/25 at 4:00 p.m. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The investigation revealed Resident #3 grabbed Resident #4's shirt and upper chest area. The investigation revealed the NHA interviewed Resident #4 on 5/2/25 at 10:15 a.m. Resident #4 said she went to talk to Resident #3. Resident #1 said Resident #3 shook her hand and with his other hand tried to reach down her shirt. Resident #4 said Resident #3 touched her skin and grazed her breast while holding her other hand. Resident #4 said Resident #3 shook her hand with his right hand and touched her breast with his left hand. Resident #4 said she did not welcome the touch, but was alright. Resident #4 said she felt safe because the nurse saw it and stopped it right away. Resident #4 said she did not feel totally safe because she was unsure what Resident #3 was up to and she did not want him on her unit. Resident #4 said she was not in pain. The investigation documented the director of nursing (DON) interviewed certified nurse aide (CNA) #4 on 5/2/25 at 10:40 a.m. regarding the incident between Resident #3 and Resident #4. CNA #1 said around 10:00 a.m. he was walking from the dining room on the second floor. CNA #1 said he saw Resident #3 near the nurses' station with his hand out towards Resident #4. He said he then saw Resident #3's hand pull at Resident #4's shirt by the collar. CNA #1 said he told Resident #3 that he could not do that. CNA #1 said he alerted one of the three CNAs sitting at the nurses' station. CNA #1 said one of the CNAs immediately took Resident #3 back to the third floor. CNA #1 said Resident #4 told him that Resident #3 was trying to touch her. CNA #1 said when he first saw Resident #3 reaching towards Resident #4 and pulling at her shirt, Resident #4 did not appear to have any reaction. CNA #1 said he immediately reported what happened to the nurse assigned to Resident #4. The assistant nursing home administrator (ANHA) and the DON interviewed a dietary aide (DA) on 5/2/25 at 4:30 p.m. The DA said she was in the dining room taking meal orders. She said Resident #4 was by the ice machine. The DA said she started walking out of the dining room and saw Resident #3 near Resident #4 with his hand on her shirt at the top. The DA said a CNA went to Resident #4 and Resident #3 right away and separated them. The DA said the CNA told Resident #3 that he could not touch other residents. The DA said Resident #4 did not appear to be upset. The DA said the CNA asked if Resident #4 was alright. The DA said Resident #4 said she was fine. The NHA interviewed CNA #1 again on 5/2/25 at 4:36 p.m. CNA #1 said Resident #3 had his hands on Resident #4's breast and her shirt area. The interview said CNA #1 did not specify if Resident #3's hands were in Resident #4's shirt or outside, just that his hands were placed near her breasts. The investigation documented the facility substantiated sexual abuse by Resident #3 towards Resident #4. B. Resident #3 (assailant) 1. Resident status Resident #3, age less than 65, was admitted on [DATE] and discharged to another facility on 6/20/25. According to the June 2025 computerized physician orders (CPO), diagnoses including severe traumatic brain injury (TBI). The 6/11/25 minimum data set (MDS) assessment revealed, through staff assessment, the resident required modified independence in cognitive decisions. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The MDS assessment documented the resident did not have physical or verbal behaviors directed at others or other behavioral symptoms not directed toward others. 2. Record review The behavior care plan, revised 5/2/25, revealed Resident #3 had a history of sexually inappropriate behaviors. Pertinent interventions included providing one-to-one staff monitoring, providing frequent checks, providing redirection and maintaining the resident's personal space. C. Resident #4 (victim) 1. Resident status Resident #4, age less than 65, was admitted on [DATE]. According to the June 2025 CPO, diagnoses including moderate intellectual disabilities, delusional disorders, insomnia, generalized anxiety disorder and depression. The 6/13/25 MDS assessment indicated the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. 2. Resident interview Resident #4 was interviewed on 6/23/25 at 10:45 a.m. Resident #4 said she approached Resident #3 to shake his hand. She said in the process, he attempted to reach out and grab her breast. Resident #4 said a staff member intervened and stopped Resident #3 before he could succeed. She said after the incident, Resident #3 returned to the third floor. III. Incident of physical abuse of Resident #2 by Resident #3 on 5/20/25 A. Facility investigation The 5/20/25 facility investigation was provided by the NHA on 6/30/25 at 4:00 p.m. The investigation documented on 5/20/25 at approximately 11:00 a.m., Resident #2 reported an incident involving Resident #3 to the NHA. Resident #2 said after offering Resident #3 a spoonful of pudding, Resident #3 touched her breast twice. Resident #2 said she wanted to avoid Resident #3. The investigation documented later that day (5/20/25) at 11:35 a.m., the NHA and the DON interviewed Resident #3 about the incident. Resident #3 admitted to grabbing Resident #2's breast and stated he was horny. The investigation documented on 5/20/25 at 12:15 p.m. that the NHA interviewed staff members. The staff members reported observing nothing specific, but noted that Resident #2 had assisted Resident #3 with pudding, during which Resident #3 touched Resident #2's breast. The NHA interviewed another resident on 5/22/25 at 12:43 p.m. The resident said they did not witness the event and only saw officers enter Resident #3's room. The resident said she was not afraid of Resident #3 and said Resident #3 was no longer funny. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The investigation concluded abuse occurred. Resident #3 was placed on a one-to-one caregiver indefinitely. B. Resident #2 (victim) 1. Resident status Resident #2, age greater than 65, was admitted on [DATE]. According to the June 2025 CPO, diagnoses including anxiety, dementia without behavioral disturbance, psychotic disturbance and mood disturbance. The 6/11/25 MDS assessment revealed Resident #2 had severe cognitive impairments with a BIMS score of seven out of 15. 2. Resident interview Resident #2 was interviewed on 6/23/25 at 11:30 a.m. Resident #2 said Resident #3 reached over and grabbed her breast while she was giving him a bite of ice cream in the dining room area on the third floor. She said after the incident, a staff member separated Resident #3 from Resident #2. IV. Staff interviews CNA #1 was interviewed on 6/23/25 at 1:15 p.m. CNA #1 said on 5/2/25 Resident #3 was in the third floor dining room and appeared to be feeling down. CNA #1 said Resident #4 approached Resident #3 to offer comfort and was touched by Resident #3. CNA #1 said he heard about the incident between Resident #2 and Resident #3 within five minutes of the incident occurring on 5/20/25. CNA #1 said a one-to-one caregiver was implemented following this event. Licensed practical nurse (LPN) #1 was interviewed on 6/23/25 at 2:00 p.m. LPN #1 said Resident #4 told her that Resident #3 grabbed her shirt. LPN #1 said both Resident #4 and Resident #3 were separated. LPN #1 said after the incident with Resident #2 and Resident #3, staff members were assigned to Resident #3 to ensure no other appropriate interactions would occur. The NHA was interviewed on 6/23/25 at 4:00 p.m. The NHA said Resident #3 had a history of sexual behaviors and that the facility had implemented a one-on-one caregiver. She said the facility was aware of Resident #3's history of inappropriate behaviors but had not implemented more restrictive interventions for him before the 5/20/25 incident. The NHA and the DON said they were not aware of Resident #3's sexually aggressive behavior before the incidents.