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	12/08/2025

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 0689 Level of Harm - Minimal harm or potential for 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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews, the facility failed to prevent an accident for one (#12) of six residents out of 22 sample residents. Specifically, the facility failed to ensure certified nurse aide (CNA) #4 transferred Resident #12 appropriately, which resulted in a fall for the resident.Findings include:I. Facility policy and procedureThe Fall Risk Assessment and Management policy, revised 9/24/25, was provided by the nursing home administrator (NHA) on 10/8/25 at 3:00 p.m. The policy read in pertinent part, The nursing staff, in conjunction with the attending physician, consultant pharmacist, therapy staff, and others, will seek to identify and document resident risk factors for falls and establish a resident-centered falls prevention plan based on relevant assessment information. Identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling.II. Resident #12A. Resident statusResident #12, age [AGE], was admitted on [DATE] and re-admitted on [DATE]. According to the October 2025 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease (COPD), wedge compression fracture of the first lumbar vertebrae, displaced fracture of the lateral malleolus of the right fibula, age-related osteoporosis, dementia with mood disturbance, left hemiplegia and diabetes mellitus type 2. The 7/18/25 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired with a brief interview for mental status (BIMS) score of four out of 15. She required a Sara lift (mechanical lift) with two-person assistance for transfers, assistance on and off the toilet, and with clothing management, and she turned side to side in bed with staff assistance.B. Record reviewThe 8/5/25 incident report documented Resident #12 was being transferred from her bed to a wheelchair by CNA #4, who was unable to complete the transfer, which caused the resident to fall. As a result of the incident, Resident #12 sustained a 7 centimeter (cm) skin tear to the left lower leg, with active bleeding noted at the time of assessment. According to the incident report, a predisposing factor was gait imbalance, and CNA #4 was unaware that the resident needed a Hoyer lift and assistance from an extra person for transfers.The 8/8/25 recapitulation of events revealed that Resident #12 refused to be transferred with the Sara lift and requested a stand pivot transfer. CNA #4 performed the stand pivot transfer which led to the fall.The activities of daily living care plan, initiated 2/16/21, documented Resident #12 had impaired physical mobility due to left-sided hemiplegia and contracture of the left hand following a stroke. She required a Sara lift and two-person assistance for transfers and used a wheelchair for mobility. The 8/5/25 progress note, documented after the incident, revealed Resident #12 sustained an approximately 7 cm skin tear located on the anterior left lower leg with active bleeding noted at the time of assessment. The surrounding skin was thin and bruised. Resident #12 was oriented and denied pain or dizziness. The nurse on duty assessed the wound, and the staff reported the incident to the resident's physician and family, as well as to the unit manager.III. Staff interviewsCNA #5 was interviewed on 10/7/25 at 4:22 p.m. CNA #5 said the staff were sup the resident with two people using the Hoyer lift. CNA #5 said after the fall on 8/5/25, Resident #12 got a skin tear. CNA #5 said the NHA regularly organized meetings with staff to discuss accident prevention. CNA #4 was interviewed via phone on 10/8/25 at 12:40 p.m. CNA #4 said she was a new employee and before the incident with Resident #12, a registered nurse (RN) told her that Resident #12 was a one-person assistance and was able to stand up and pivot.CNA #4 said she tried to stand-pivot Resident #12 but the resident fell. CNA #4 said after the incident, two staff members came to help, and they put the resident in bed using a Hoyer lift. She said the RN took care of the bleeding on the resident's left leg. CNA #4 said she did not know anything about Resident #12 prior to transferring the resident and she did not take care of the resident after the incident on 8/5/25.RN #2 was interviewed on 10/8/25 at 10:05 a.m. RN #2 said she did not remember anything else about Resident #12's fall because it happened months ago. She said nurses should communicate changes in care plans and transfer statuses to CNAs during rounds.The director of nursing (DON) was interviewed on 10/8/25 at 3:20 p.m. The DON said the best way to determine how to transfer a resident was a multidisciplinary decision between previous facilities' orders, physical therapy (PT) and nursing. The DON said that the statuses for transfers and mechanical lift assistance were in the residents' care plans; however, CNAs did not have access to the entire care plan. She said CNAs could see what they needed to know for resident care or ask a nurse if they needed further information on a resident's transfer status. The DON said CNA #4 transferred Resident #12 by herself because the resident refused the mechanical lift, which caused the resident to fall and sustain a skin tear. The DON said CNA #4 did not ask

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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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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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 0760 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 two (#19 and #18) of nine residents reviewed for medication management were free from significant medication errors out of 22 sample residents.Resident #19 was admitted to the facility on [DATE] with diagnoses of dementia with behavioral disturbance, respiratory failure, peripheral vascular disease, and thrombocytopenia (a deficiency of platelets in the blood). On 8/21/25 at 6:38 p.m. Resident #19 was sent out to the emergency department from the facility due to an acute change of condition. Resident #19 was found to have low blood pressure, a decrease in responsiveness, an increase in lethargy and was unable to follow the nursing staff's commands. While at the hospital, it was documented Resident #19 suffered an accidental medication overdose after she was given another resident's medications. It was documented the resident received amlodipine (used to treat high blood pressure), metoprolol (used to relax blood vessels and slow heart rate), hydralazine (used to treat high blood pressure), and oxycodone (a narcotic pain medication). Resident #19 was administered 2 milligrams (mg) of Narcan (a medication used to reverse opioid overdose) by the paramedics, and was awake and had spontaneous respirations afterwards.Additionally, Resident #18 was administered his roommate's medications on 9/21/25.Specifically, the facility failed to:-Ensure Resident #19 did not receive another resident's (Resident #26) medications, which required transfer to the hospital for treatment; and,-Ensure Resident #18 did not receive another resident's (Resident #16) medications.Findings include:Record review and interviews confirmed the facility corrected the deficient practice prior to theonsite investigation from 10/7/25 through 10/8/25, resulting in the deficiency being cited as past noncompliance with a correction date of 9/22/25.I. Medication errors on 8/21/25 and 9/21/25The facility failed to ensure a licensed nurse administered medications to the correct resident.Resident #19 was administered another resident's (Resident #26) medications, which caused the resident to experience a change in condition and the resident was sent to the hospital for treatment. Additionally, Resident #18 was administered Resident #16's medications which led to a change in condition on 9/21/25.II. Facility's plan of correctionThe corrective action plan the facility implemented in response to Resident #19 and Resident #18's medication error incidents on 8/21/25 and 9/20/25 was provided by the nursing home administrator (NHA) 10/8/25 at 4:07 p.m.The stated purpose of the plan was to address the significant medication errors and prevent any additional residents from suffering any adverse outcome.The plan revealed the following:A. Identification of other residentsAn audit of all residents was conducted to ensure an updated photo was present in the electronic medical record (EMR). New, updated photos were uploaded to each resident's EMRs, which was completed by 9/22/25.B. Systemic changesAll applicable facility policies and procedures were reviewed and revised.The assistant director of nursing (ADON) reeducated licensed nurses on the facility's policies regarding medication administration and medication error reporting. All nursing staff were educated prior to working their next shift, completed 9/22/25.The NHA did not allow the two agency nurses who improperly administered medications causing the significant medication errors to return to the facility. The NHA hired seven new nurses to the facility staff to decrease the facility's use of agency staff. The NHA limited agency staff usage to only agency staff members who had worked consistently with the facility in the past, and reviewed the licenses and competencies of each agency staff member prior to their next shift at the facility.C. MonitoringThe director of nursing (DON) or designee would observe medication administration two times per day for four weeks before evaluating to see if additional observations were needed or if the frequency of observations could be decreased at that time. Observations would occur across shifts and with various staff members, including agency staff members.Monthly medication audits were also initiated and were ongoing.The NHA implemented a performance improvement plan as a means to gather and process information from the audit. Findings would be reported at the monthly quality assurancemeetings.The facility's determined date of compliance was 9/22/25.III. Professional referenceAccording to [NAME], P.A., [NAME], A.G et.al,, Fundamentals of Nursing, 10th ed., Elsevier, St.[NAME], Missouri, pp. 606-607, Take appropriate actions to ensure the patient receivesmedication as prescribed. To prevent medication errors, follow the seven rights of medicationadministration consistently every time you administer medications:1. The right medication2. The right dose3. The right patient4. The right route5. The right time6. The right documentation7. The right indication.IV. Facility policy and procedureThe Medication Administration policy, revised 10/3/25, was provided by the NHA on 10/8/25 at 3:58 p.m. It read in pertinent part, Medications are administered in