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	01/16/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47151 Based on observations, record review and interviews, the facility failed to ensure care for residents in a manager and in an environment that maintains or enhances each resident's dignity and respect, in full recognition of his or her individuality for one of four residents out of 53 sample residents reviewed for respect and dignity. Specifically, the facility failed to ensure a resident was provided privacy while using the restroom. Findings include: I. Resident status Resident #7, age greater than 65, was admitted on [DATE]. According to the January 2025 computerized physician orders (CPO), diagnoses included schizophrenia, post traumatic stress disorder (PTSD) and history of falls. The 12/10/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. He was dependent on total assistance from staff for toileting hygiene, transfers, and lower body dressing. He needed substantial to maximal assistance with bed mobility and bathing, and needed set up help only with eating, oral and personal hygiene. II. Record review Resident #7's activities of daily living (ADL) care plan documented Resident #7 haD an ADL self-care performance deficit due to impaired balance, muscle weakness, decreased endurance, poor trunk control, cognitive impairments and decreased motivation to perform tasks. Pertinent interventions included Resident #7 needed assistance from two people for transferring. Resident #7 had incontinent episodes of bowel and bladder and required assistance with incontinence care and clothing management after an episode. Resident #7 transferred onto the toilet for bowel movements occasionally. III. Observations (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/14/25 at 5:15 p.m. Resident #7 was sitting on the toilet in his room. The door to Resident #7's room and bathroom were both open, and the bathroom was immediately to the left of the room entrance. The bathroom door was opened at an angle so Resident #7 was visible from the hallway. Resident #7 was seated on the toilet, his pants were around his legs and he was holding a grab bar on the wall of the bathroom. Resident #7 grunted loudly twice and then yelled' here it comes' while seated on the toilet. An unidentified certified nurse aide (CNA) walked past Resident #7's room while Resident #7 was on the toilet with the door open, looked at the doors and continued to walk down the hallway. The unidentified CNA did not check on the resident or close the door to the room while the resident was using the restroom and was exposed to the facility hallway. Immediately after the unidentified CNA passed Resident #7's room, CNA #4 exited Resident #7's room with a clear bag of trash in her hand while Resident #7 was still in the bathroom and exposed to the facility hallway. She did not close the door to Resident #7's room, walked across the hallway and placed the clear trash bag inside a refuse container. CNA #4 walked back toward Resident #7's room and closed the door to the room. IV. Staff interviews CNA #5 was interviewed on 1/15/25 at 1:00 p.m. CNA #5 said if a resident was able to independently sit in the bathroom without assistance either the bathroom door or room door should be closed for privacy. CNA #5 said she was trained to ensure the residents' room doors were closed for privacy unless the resident was claustrophobic and needed the door open. CNA #5 said if a resident needed the door open, the resident should still be shielded for privacy. CNA #4 was interviewed on 1/16/25 at 2:15 p.m. CNA #4 said she thought she was in Resident #7's room with his roommate on 1/15/25. CNA #4 said sometimes Resident #7 did use the bathroom himself with the bathroom door open so he could call someone when he needed help. CNA #4 said if a resident wanted the bathroom door open while they used the bathroom then the door to the resident's room should be closed or the resident should be provided another form of privacy. The director of nursing (DON) was interviewed on 1/16/25 at 10:15 a.m. The DON said Resident #7 was fine with his bathroom door open unless his roommate's family or visitors were in the room and then he would want the door closed.

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51710 Based on observations, record review, and interviews, the facility failed to honor a resident's choice for laundry services, for one (#113) out of 33 residents reviewed out of 53 sample residents. Specifically, the facility failed to ensure Resident #113's laundry was consistently saved and stored for his wife to launder due to his multiple allergies. Findings include: I. Facility policy and procedure The facility's Promoting/Maintaining Resident Self-Determination policy, undated, was provided by the nursing home administrator (NHA) on 1/16/25 at 10:53 a.m. It read in pertinent part, It is the practice of this facility to protect and promote resident rights by promoting and facilitating resident self-determination through support of resident choice. The facility will ensure that each resident has the opportunity to exercise his/her autonomy regarding those things that are important in his/her life such as interests and preferences. Policy compliance guidelines included: -All staff members involved in providing care to residents will promote and facilitate resident self-determination; -Each resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident; -All aspects of care and services will be discussed in the care plan meeting and documented as such; -The care plan will reflect resident choices when applicable; and, -The facility will accommodate the resident's preferences to the extent possible and as agreed upon by the resident's sponsor and physician. II. Resident #113 A. Resident status Resident #113, age greater than 65, was admitted on [DATE]. According to the January 2025 computerized physician orders (CPO), diagnoses included unspecified dementia without behavioral/psychotic/mood disturbance and anxiety, post-traumatic stress disorder (PTSD) and gout (a type of arthritis). (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 11/11/24 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired with a brief interview for mental status score (BIMS) of two out of 15. He was independent with bed mobility, transfers and locomotion. He required partial assistance with oral/toileting hygiene and showering, and supervision with dressing. B. Resident representative interview and observations Resident #113's representative was interviewed on 1/13/25 at 2:28 p.m.The representative said a bunch of Resident #113's clothes were previously missing and she was working with one of the facility's social workers regarding the issue. She said Resident #113 was previously exposed to Agent Orange (tactical herbicide) which caused him to develop a lot of allergies. The representative said Resident #113 had gotten rashes in the past if the wrong soap or laundry detergent was used. She said she had requested Resident #113's dirty laundry to be stored and saved for her to launder due to his allergy to most commercial laundry products. She said there was a lot of turnover with the nurses and the certified nurse aides (CNA) in the facility, so she felt like she had to micromanage his care. She said she did not understand why it was so difficult for the facility's staff to ensure his laundry was in his closet for her to collect. There was a sign taped to Resident #113's bathroom door stating he was allergic to aloe and to only use the shampoo that was in his closet. Another laminated sign was taped to Resident #113's closet door stating his wife wanted to do his laundry and facility staff should store his dirty laundry in the laundry basket inside the closet. A laundry basket was inside his closet. C. Record review A grievance form, dated 12/23/24, revealed Resident #113's wife reported the resident was missing pants, pajama pants and multiple shirts. She reported often finding other resident's clothing in Resident #113's room and not his clothing. An investigation was conducted by a facility administrator on 12/23/24, and five pairs of pants and five shirts were found in his closet. The administrator left a voicemail for Resident #113's wife on 12/27/24. The facility administrator reported his clothes were located in the facility laundry and other resident's clothing were removed from Resident #113's room. A review of Resident #113's electronic medical record (EMR) documented he had allergies to hydrocodone (pain medication), valproic acid (seizure medication, penicillins (antibiotics), milk and milk products, pork, aloe, corn and lavender. A skin integrity care plan, initiated on 9/7/22 and revised on 8/6/24, revealed Resident #113 was at risk for impaired skin integrity due to anticoagulant (blood thinner) use. He had fragile skin and poor safety awareness. Interventions included encouraging good nutrition and hydration to promote healthier skin, assessing his risk of skin breakdown quarterly and as needed, and completing skin assessments weekly. -Review of Resident #113's EMR did not reveal documentation addressing his allergies, skin issues with topical products and detergents, or laundry preferences. III. Staff interviews (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Certified nurse aide (CNA) #1 was interviewed on 1/16/25 at 9:34 a.m. CNA #1 said Resident #113's wife did his laundry. She said he was frequently incontinent and would sometimes go through all of his clean clothes, so his clothes would be sent to the facility's laundry room. She said the laundry department was aware of Resident #113's allergies and did his laundry different from the other residents. Licensed practical nurse (LPN) #2 was interviewed on 1/16/25 at 9:48 a.m. LPN #2 said Resident #113's wife did his laundry. She said his wife did allow the facility to do his laundry when she was sick, but otherwise she wanted to primarily do it. She said she would ask Resident #113's wife to bring additional clothing in for him due to his incontinence. The director of nursing (DON) was interviewed on 1/16/25 at 1:51 p.m. The DON said if a resident's family asked to do their laundry, the facility had signs posted for staff to place on their closet and laundry bins they could put inside the closet. She said it was important to follow a resident's request because it was their right and the facility should honor their preferences, especially if they affect their health. The DON was interviewed again on 1/16/25 at approximately 5:45 p.m The DON said the facility had begun providing education with the facility's staff to discuss the resident's laundry and laundry preferences.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 47350 Based on record review and interviews, the facility failed to ensure six (#98, #16, #127, #106, #116 and #67) of 33 residents reviewed for abuse out of 53 sample residents were free from abuse. Specifically, the facility failed to: -Prevent resident to resident physical abuse between Resident #98 and Resident #16, who had a history of physically and verbally aggressive behaviors towards other residents and staff; -Protect Resident #67 from physical abuse from Resident #127; -Protect Resident #106 from physical abuse from Resident #127; and, -Prevent a resident to resident physical abuse altercation between Resident #116 and Resident #127. Findings include: I. Facility policy and procedure The Abuse Prevention policy and procedure, revised 12/17/18, was provided by the nursing home administrator (NHA) on 1/13/25 at 1:10 p.m. It read in pertinent part, Residents will not be subjected to abuse by anyone including, but not limited to, facility staff, other residents, consultants or volunteers, staff or other agencies servicing the resident, family members or legal guardians, friends or other individuals. Physical abuse is not limited to hitting, slapping, punching and kicking. Assess, care plan and monitor residents exhibiting needs and behaviors that predispose them to have conflict with others or to subject them to neglect by staff (such as residents with history of aggressive behaviors; residents who enter other residents' rooms, residents with self injury behaviors; residents with communication disorders; resident requiring extensive or total nursing care). II. Incident of physical abuse between Resident #98 and Resident #16 on 1/6/25 A. Facility investigation The 1/6/25 abuse investigation documented a witnessed resident-to-resident physical altercation between Resident #98 and Resident #16. The staff observed Resident #98 entering the third floor dining room and Resident #16 exiting the third floor dining room. Their wheelchairs bumped together when passing each other. Resident #98 reached over and slapped Resident #16 in the face. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The staff separated the two residents. Resident #16 said that Resident #98 had slapped him. Resident #98 denied slapping Resident #16 and said Resident #16 had yelled at him. Resident #98 said he had slapped Resident #16 a long time ago because Resident #16 had made him angry. The investigation indicated the two residents were separated and placed on 15-minute checks. The on-duty nurse performed skin and pain assessments on both residents and neurological checks were initiated for Resident #16. It indicated that Resident #16 had denied pain or being afraid of Resident #98. The facility investigation unsubstantiated the allegation of physical abuse at the conclusion of the investigation due to Resident #98's poor impulse control and therefore the slap was unintentional and there was no observed pain, injury or animosity from either Resident #98 or Resident #16. -However, abuse occurred as Resident #98 slapped Resident #16. B. Resident #98 - assailant 1. Resident status Resident #98, age less than 65, was admitted on [DATE]. According to the January 2025 computerized physician orders (CPO), diagnoses included traumatic brain injury (TBI) and dementia. The 11/25/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status score (BIMS) of ten out of 15. He was dependent with toileting, personal hygiene, bed mobility, transfers and required substantial/maximal assistance with eating. The assessment indicated the resident exhibited verbal behaviors towards others. The assessment did not indicate the resident exhibited physical behaviors towards others. 2. Resident observation and interview On 1/13/25 at 10:00 a.m. Resident #98 declined to be interviewed with difficult to understand speech. On 1/13/25 at 1:04 p.m. Resident #98 was sitting at a table in the dining room. He was sitting alone at a table, feeding himself and cursing, which was not directed to anyone. 3. Record review (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The behavior care plan, initiated 5/18/21 and revised 11/12/24, indicated Resident #98 had behaviors of being physically and verbally combative with staff, invading other residents' personal space, taking food off of other residents' plates, inappropriate behaviors toward females and poor impulse control related to his TBI. Interventions included trying different activities to increase resident engagement, initiating a behavior chart and reward program, offering to take Resident #98 to his room if his behavior was agitating other residents, encouraging the resident to develop more appropriate methods of coping and interacting, reviewing diet regimen to address his food seeking behaviors and intervening as necessary to protect the rights and safety of others. The 8/13/24 resident to resident physical altercation care plan, initiated 9/5/24, documented a female resident had reported that Resident #98 had hit her. Interventions included separating residents and initiating 15-minute checks with one-to-one support given until calm, moving resident to another floor for decreased stimulation and calmer environment with more activity involvement, following up with behavioral health services, reviewing bowel and pain regimen evaluating for neurology follow up, ruling out a medical cause, during checks noting location, environment and people surrounding him remove him from a highly stimulated, loud or crowded area and assisting as needed. The 1/6/25 resident to resident physical altercation care plan, initiated 1/6/25, indicated that Resident #98 had a resident to resident physical altercation while he was trying to enter the dining area and another resident was exiting the dining area when their wheelchairs bumped. Interventions included separating residents and initiating 15-minute checks, adding a pureed snack at 10:00 a.m. and increasing portions to double portions to reduce behavior of seeking other residents left over food in the dining area, placing a sign at the end of the steam table for staff not to park the hot food holding tower in the dining room entry to prevent resident collisions and reviewing resident mood and behavior with the psych interdisciplinary team (IDT). The facility daily behavior monitoring, from 9/14/24 to 1/14/25, documented Resident #98's physically aggressive behaviors including kicking/hitting, grabbing and pinching/scratching/spitting on 9/23/24, 10/31/24, 11/23/24, 11/24/24, 12/20/24, 12/30/24, 1/5/25, 1/6/25, 1/12/25 and 1/14/25. The 8/31/24 nursing progress note documented Resident #98 and another resident were found with wheelchair wheels entangled in the entrance way of the dining room. The other resident stated that they had been hit by Resident #98. The residents were separated and 15-minute checks were initiated. The 9/11/24 nursing progress note documented Resident #98 was swearing at the nurse on two separate occasions because he was upset that the nurse was not listening to him. The 9/12/24 social services progress note documented Resident #98 could be verbally and physically abusive toward others and that Resident #98 had a recent altercation with another resident. Resident #98 had been moved to another floor which was smaller with more activity involvement. The 12/16/24 behavior progress note documented Resident #98 had been yelling, wandering and exit seeking during the shift. The 12/25/24 behavior progress note documented Resident #98 had been yelling and cursing at staff and other residents. He was assisted out of the dining room and started to attempt to make himself vomit. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 12/25/24 behavior progress note documented Resident #98 was swearing at staff during bedtime care. Resident #98 was also swearing and trying to strike staff when he was in the middle of the hallway and staff asked him to move. The 12/31/24 behavior progress note documented Resident #98 became verbally aggressive with staff when asked to move his wheelchair and kicked staff in the shin twice. He was observed later to be verbally aggressive toward another resident and backed up his wheelchair into the other resident's wheelchair. The 1/3/25 behavior progress note documented Resident #98 attempted to hit staff when he was assisted with bedtime care. The 1/5/25 behavior progress note documented Resident #98 started eating food off of other residents' plates. A certified nurse aide (CNA) attempted to redirect the resident and he kicked her in the shin and spit food out at her. The 1/6/25 nurse progress note documented Resident #98 passed another resident and Resident #98 reached up and slapped them. Resident #98 denied slapping the other resident and said the other resident had yelled at him. He then said he had slapped the other resident a long time ago because he had made him angry. The 1/13/25 social services progress note documented the social worker spoke to Resident #98 regarding the physical altercation with another resident. Resident #98 was asked not to target or approach the other resident and not have any negative interactions with the other resident. C. Resident #16 1. Resident status Resident #16, age 81, was admitted on [DATE]. According to the January 2025 CPO, diagnoses included dementia and post traumatic stress disorder (PTSD). The 10/29/24 MDS assessment revealed the resident had severe cognitive impairments with deficits in short and long term memory per staff assessment. He was dependent with toileting, substantial/maximal assistance with personal hygiene, transfers, partial/moderate assistance with bed mobility and set up assistance with eating. The assessment indicated the resident exhibited physical and verbal behaviors towards others. 2. Record review The post traumatic stress disorder (PTSD) care plan, initiated 7/26/24 and revised 9/24/24, documented Resident #16 had a history of PTSD related to his experiences and being wounded as a [NAME] in the Vietnam war. It indicated his triggers might be from lights at night or flood lights. Interventions included administering medications as ordered, encouraging responsible party in plan of care, facilitation referrals to community resources, monitoring resident mood and behaviors. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 12/17/24 resident to resident physical altercation care plan, initiated 12/17/24, documented Resident #16 was a victim in a resident to resident altercation. Resident #16 was being held by the wrist by another resident while the other resident was swinging a hat hitting him in his left shoulder. Interventions included assessing the resident head to toe and keeping the resident in line of sight. The 1/6/25 resident to resident physical altercation care plan, initiated 1/6/25, documented Resident #16 was slapped by another resident when their wheelchairs bumped into each other at the entrance of the dining room. Interventions included placing residents on monitoring, separating and assessing residents every 15 minutes and decongesting the entrance to the dining room. -A review of Resident #16's comprehensive care plan did not reveal personalized interventions to prevent further abuse from aggression by other residents. The 1/6/25 nursing progress note documented Resident #16 was slapped by Resident #98 while they were passing each other in the entry of the dining room. Redness was noted on the left side of his face but he denied pain or being fearful. D. Staff interviews CNA #6 was interviewed on 1/15/25 at 10:27 a.m. CNA #6 said Resident #98 would lash out towards others when he was unable to articulate or make his needs known. He said Resident #98 could get verbally and physically aggressive at times. He said Resident #16 also had difficulties communicating. He said since the recent resident to resident altercation between Resident #98 and Resident #16, Resident #16 did not seem comfortable around Resident #98. He said both residents used to get along but now Resident #16 seemed to want nothing to do with Resident #98. He said when Resident #16 saw Resident #98 he would often shake his finger at Resident #98 and say you, you. He said staff would keep Resident #98 and Resident #16 apart, especially during meals and sat them at different tables. Licensed practical nurse (LPN) #3 was interviewed on 1/16/25 at 9:30 a.m. LPN #3 said Resident #98 was very attention seeking. He said he was not aware of any recent resident to resident physical altercations but Resident #98 was on 15-minute checks for his behaviors and would be summarized and documented in the medical record as a behavior note for each shift. He said Resident #98 did have a previous resident to resident physical altercation on another floor and had been moved to the current floor because of behaviors with another resident. He said if Resident #98 was unable to communicate he would lash out. He said he was unaware of any special interventions that were in place from a recent alteration with another resident. He said when there was a resident to resident physical altercation, staff would immediately separate the residents, placed them on 15-minute monitoring, notified administration and the police. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Unit manager (UM) #2 was interviewed on 1/16/25 at 10:20 a.m. UM #2 said Resident #98 had a history of a TBI and had a speech impediment and difficulty in communicating. She said he was originally on another floor and had been moved to the current floor because of behavior issues with others. She said the current floor was a calmer environment for him. She said Resident #98 had a recent physical altercation with Resident #16. She said Resident #98 had reached over and slapped Resident #16 in the face when their wheelchairs bumped at the entrance of the dining room. She said Resident #98 was very impulsive. She said the staff discussed his behaviors once a week in IDT. She said Resident #16 had reacted to Resident #98 by calling out and Resident #98 had come to her office and been upset by this. She said Resident #98 had been told by staff that Resident #16 called out and not to take it personally. She said Resident #98 had been on 15-minute checks continuously for his behaviors. She said the staff had tried to decongest the entry of the dining room to prevent this from happening again. The director of nursing (DON) and the NHA were interviewed together on 1/16/25 at 1:51 p.m. The DON said Resident #98 had a long history of behaviors and physical aggression towards others. She said Resident #98 had been on another floor and had been moved to the current floor for less stimulation. The DON said there had been multiple referrals for Resident #98 for more appropriate placement, including a TBI center. She said Resident #98 was also being followed by psychiatric staff. The DON said both Resident #98 and Resident #16 had their ups and downs. She said both residents had a tendency to call out. She said Resident #98's behavior had improved while on the current floor. She said Resident #98's behaviors seemed to have escalated over the holidays. The DON said the nursing staff notified the provider, obtained a urinalysis, reviewed his chart, checked his bowel and bladder program, limited his caffeinated beverages, reviewed his medications, reviewed his pain levels, obtained a neurology referral and reviewed his diet. The DON said the nursing staff were still trying to regiment Resident #98's day and were looking into a behavioral reward system. The DON said she was not aware of any behavior changes or ongoing tension between Resident #98 and Resident #16 since the altercation. She said CNA #6 worked with Resident #98 and Resident #16 consistently and knew the residents well. She said if CNA #6 had identified there was a behavior change by Resident #16 towards Resident #98 after the physical altercation, he would know. She said if Resident #16 was no longer comfortable around Resident #98 and no longer wanting to interact with Resident #98 since the altercation, that would substantiate the allegation of physical abuse. She said she would do further research into the behavior changes between the two residents. 51710 III. Incident of physical abuse between Resident #67 and Resident #127 on 9/23/24 A. Facility investigation The 9/23/24 facility investigation documented Resident #67 was in the dining room yelling obscenities at staff members who were around the corner. Resident #127 became agitated from the obscenities and struck Resident #67. It documented Resident #67 then swung his arms trying to hit Resident #127 back before the staff could intervene. Resident #67 sustained a skin laceration above his right eyebrow, which was treated with normal saline and steri-strips. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The investigation documented the residents were separated, staff and residents were interviewed, the resident's care plans were reviewed, and pain/medication reviews were conducted. Fifteen minute checks were initiated and behavioral health services were contacted. Resident #67 was interviewed and said he went to the table that Resident #127 was sitting at and asked him for help opening something. He said Resident #127 initially agreed, but then got mad and hit Resident #67 across the face. He said he hit Resident #127 back three times, but not as hard as Resident #127 hit him. Resident #67 said he felt safe as long as Resident #127 was not around. Resident #127 was interviewed and said Resident #67 was yelling at staff members then came after him. He said he told Resident #67 to stop, which made Resident #67 mad. Resident #127 said he did not physically touch or throw objects near Resident #67. Resident #127 was unable to complete the interview. The investigation documented Resident #127 appeared overstimulated by the environment and kept looking around worried. The investigation documented the staff witnessed Resident #67 and Resident #127 physically fighting each other. Resident #67 was in the dining room angry about his coffee, and started screaming obscenities. The staff member passed him and went into the kitchen. It documented the staff member heard a commotion and witnessed Resident #67 throwing a glass of juice and Resident #127 standing next to him with his right fist drawn back. It documented Resident #127 stated Resident #67 went after him for no reason, and Resident #67 should not be allowed to talk that way. The investigation documented Resident #67 was sent to the hospital days after the altercation due to low oxygen levels and lethargy. It documented a CT scan of the head and cervical spine and a chest x-ray were conducted, all negative for any findings. The results of the investigation documented that abuse was unsubstantiated as both elements of physical abuse were not met. It documented that even though Resident #67 obtained a skin tear, there was a lack of evidence proving Resident #127 intended to harm Resident #67 instead of Resident #127 reacting negatively after becoming overstimulated. Additionally, the conclusion documented although Resident #67 obtained a laceration to his eyebrow, no serious bodily injury occurred. -However, Resident #67 and Resident #127 were witnessed fighting each other and Resident #67 said he was hit by Resident #127. B. Resident #67 - victim 1. Resident status Resident #67, age 82, was admitted on [DATE]. According to the January 2025 CPO, diagnoses included Alzheimer's disease with late onset, unspecified dementia with other behavioral disturbance, anxiety disorder and moderate and recurrent major depressive disorder. The 11/20/24 MDS assessment revealed the resident was cognitively impaired with a BIMS score of three out of 15. He required substantial assistance with toileting/personal hygiene and dressing. He was dependent on staff for transfers and locomotion via wheelchair. The assessment indicated the resident exhibited wandering behavior. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review A behavior care plan, initiated on 5/24/24 and revised on 1/13/25, revealed Resident #67 could be verbally and physically aggressive towards others related to his diagnosis of dementia The resident had a history of delusions and hallucinations. It documented Resident #67 had previously thrown things, wandered into other resident's rooms, made inappropriate sexual comments to others and made inappropriate jokes about being mad at or harming others. Interventions included scheduling pain medication, increasing supervision of Resident #67 through various methods, assessing for verbal and non-verbal signs of pain and offering Resident #67 tasks/activities that focused his attention. A behavioral symptoms care plan, initiated on 9/24/24, revealed Resident #67 could affect others by directing negative physical and verbal behaviors towards them. Interventions included assessing for physiological causes of aggressive behavior, a pain regimen review, providing redirection and/or one-to-one supervision as needed and intervening when Resident #67 exhibited negative behaviors towards others. A nurse progress note, dated 9/23/24 at 6:55 p.m., revealed Resident #67 was in the dining room angry about his coffee when he started screaming obscenities. It documented the nurse heard a commotion and observed Resident #67 throwing a cup of juice. It documented Resident #127 was standing next to Resident #67 with his right fist drawn back. It documented Resident #67 sustained a one and a half centimeter (cm) laceration above his right eyebrow. It documented the laceration was cleansed with normal saline and steri-strips were applied. It documented Resident #67's provider and power of attorney (POA) were notified. C. Resident #127 - assailant 1. Resident status Resident #127, age 73, was admitted on [DATE]. According to the January 2025 CPO, diagnoses included Alzheimer's disease, delusional disorders, post-traumatic stress disorder (PTSD), and mild dementia , in other diseases, with other behavioral disturbance. The 12/26/24 MDS assessment revealed the resident was cognitively impaired with a BIMS score of six out of 15. He required supervision with ambulation, transfers, and personal hygiene. He required substantial assistance with toileting hygiene and showering. He experienced hallucinations and delusions. The MDS assessment indicated the resident had symptoms of negative physical and verbal behaviors towards others, and negative behaviors not directed towards others. 2. Record review An altercation care plan, initiated on 9/24/24, revealed Resident #127 was involved in a resident to resident altercation on 9/23/24. It documented Resident #127 could be triggered by overstimulation and direct negative physical and verbal behaviors towards others. Interventions included encouraging a low stimulation dining location, assessing for physiological causes of aggression and providing redirection and/or one to one supervision as needed. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The behavior care plan, initiated on 11/4/23 and revised on 1/6/25, revealed Resident #127 was physically and verbally aggressive related to his dementia with paranoia, delusion and PTSD. It documented Resident #127 became overstimulated at times and would strike out at others who made noises or touched him. Interventions included providing a calm environment, administering medications as ordered, keeping the resident near a staff member when at group activities to redirect if he had increased agitation, analyzing triggers and what deescalated the resident's behavior and staff to intervene before the agitation escalated. A nurse progress note, dated 9/23/24 at 7:11 p.m., revealed the nurse overheard Resident #67 scream an obscenity. The nurse entered the dining room and saw Resident #127 standing next to Resident #67 with his right hand raised. It documented Resident #127 said Resident #67 should not be allowed to talk that way. It documented Resident #67 sustained a laceration. It documented Resident #127 sustained no injuries, and his provider and POA were notified. IV. Incident of physical abuse between Resident #106 and Resident #127 on 12/20/24 A. Facility investigation The 12/20/24 facility investigation documented screaming was heard from Resident #127's room. When the staff approached, Resident #106 was on the floor facing into Resident #127's room, indicating she wandered in. It documented Resident #127 was standing over Resident #106. Resident #106 was attempting to kick Resident #127, however no contact was made. The investigation documented no injuries were observed on either resident. The investigation documented the residents were separated, the staff and residents involved were interviewed, and the resident's care plans were reviewed. Fifteen minute checks were initiated and a stop sign was placed on the outside of Resident #127's room to deter wandering residents from entering. The investigation documented laboratory (lab) work was requested for Resident #127. -Stop sign was in place, but was not hung up due to Resident #127 being under one-to-one supervision. His door was closed to deter other residents from entering his room. Resident #106 was interviewed and talked nonsensically when asked about the altercation. She was unable to verbalize the events and she appeared angry. Resident #127 was interviewed and said Resident #106 went into his room. Resident #127 said she did all the time. He said she was not allowed to be in there and she got in his face. He said he went to close his room door and pushed Resident #106 to the ground. -The investigation documented Resident #127 had previously been physically aggressive towards others if he felt they were invading his space and his room door was closed when Resident #106 entered. The results of the investigation documented that abuse was unsubstantiated as it did not meet all of the requirements elements of abuse criteria, even though there was evidence of intent to harm. It documented neither resident sustained physical injuries, reported any pain, or exhibited signs and symptoms of fear or emotional distress. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-However, Resident #127 said he pushed #106 and Resident #106 was found lying on the floor attempting to kick Resident #127. B. Resident #106 - victim 1. Resident status Resident #106, age 77, was admitted on [DATE]. According to the January 2025 CPO, diagnoses included dementia in other diseases, severity unspecified, with agitation, anxiety disorder and recurrent major depressive disorder. The 12/6/24 MDS assessment revealed the resident was cognitively impaired with a BIMS score of three out of 15. She was independent with eating, ambulating and transfers. The assessment exhibited wandering behavior. 2. Record review An altercation care plan, initiated on 12/20/24 and revised on 12/26/24, revealed Resident #106 was involved in a resident to resident altercation on 12/20/24. She went into another resident's room, which agitated him, and prompted him to push Resident #106 to the ground. Interventions included one-on-one supervision, conducting an activity review and implementing personalized activities and removing the resident to a calm/safe environment to de-escalate as necessary. A behavior care plan, initiated on 1/22/22 and revised on 8/1/24, revealed Resident #106 would often attempt to offer unsolicited help to other residents, and would lean in close to them if they did not respond to her. Interventions included redirecting residents behavior, administering medications as ordered and offering activities that diverted her attention. A nurse progress note, dated 12/20/24 at 2:03 p.m., revealed screaming was heard from Resident #127's room. It documented when the nurse approached, Resident #106 was lying on the floor attempting to kick Resident #127, who was standing over her. It documented Resident #106 was temporarily removed from the unit to calm down, 15-minute checks were initiated on Resident #106. The provider and her POA were notified. C. Resident #127 - assailant 1. Record review An altercation care plan, initiated on 12/20/24 and revised on 12/30/24, revealed Resident #127 had territorial behaviors related to dementia and PTSD and would become aggressive towards others if he felt they were invading his space. Interventions included placing a stop sign and door alarm on Resident #127's door, lab work, administering medications as ordered and intervening as necessary to protect the safety of others. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nurse progress note, dated 12/20/24 at 1:41 p.m., revealed the nurse heard screaming from Resident #127's room and found him standing over Resident #106. It documented Resident #106 appeared to have entered Resident #127's room and she was lying on the floor attempting to kick Resident #127. It documented both residents were immediately separated and 15-minute checks were initiated on Resident #127. It documented Resident #127's provider was notified and lab work was ordered. It documented a voicemail was left for Resident #127's power of attorney. III. Incident of physical abuse between Resident #116 and Resident #127 on 1/3/25 A. Facility investigation The 1/3/25 facility investigation documented Resident #116 was observed falling backwards and landing on his buttocks. When the staff approached Resident #116, Resident #127 was standing over him. The investigation documented Resident #116 did not hit his head. The investigation documented Resident #127 had finger indentations and scratches on his right arm. Resident #127 had full range of motion to the extremity and had no reports of pain. Resident #127 said he was just standing there when Resident #116 grabbed his arm and twisted it trying to push him out of the way. Resident #127 said he had to push Resident #116 to the ground so he would not fall. He said he had to defend himself. The investigation documented the residents were separated, the staff within the vicinity of the incident were interviewed, the residents were interviewed, the resident's care plans were reviewed and behavioral health services was contacted. Fifteen-minute safety checks were initiated. The investigation documented lab work and a urinary analysis (UA) was requested. Resident #116 was interviewed and said he was just standing there and was pushed down. The investigation documented the staff witnessed Resident #116 falling from around the corner. It was unclear which resident pushed first based on the interviews and the altercation being unwitnessed. Resident #127 did have finger indentations and superficial scratches on his arm aligning with the claim of Resident #116 grabbing Resident #127's arm. The results of the investigation documented that abuse was unsubstantiated as it did not meet all of the requirements of abuse because there was no intent to harm, the reddened area to the arm was resolved moments after the event occurred, there were no further injuries and neither resident showed signs of distress. -However, Resident #127 said he pushed Resident #116 and said Resident #116 grabbed his arm. B. Resident #116 - assailant Resident #116, age 76, was admitted on [DATE] and readmitted on [DATE]. According to the January 2025 CPO, diagnoses included unspecified Alzheimer's disease, schizoaffective disorder (mental disorder), and dementia, in other diseases, with other behavioral disturbance. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 11/27/24 MDS assessment revealed the resident was cognitively impaired with a BIMS score of three out of 15. He was independent with ambulation, bed mobility, and transfers. He exhibited wandering behavior. 2. Record review An altercation care plan, initiated on 1/3/25, revealed Resident #116 was involved in a physical altercation with another resident. Interventions included 15-minute monitoring, encouraging the resident to participate in meaningful activities, ordering lab work and referring the resident to behavioral health services for medication review. A behavior care plan, initiated on 6/4/24 and revised on 6/19/24, rev[TRUNCATED]

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47350 Based on observations, record review and interviews the facility failed to ensure the minimum data set (MDS) assessment accurately reflected the residents'status based on the criteria outlined in the resident assessment instrument (RAI) for one (#83) of 18 residents reviewed out of 53 sample residents. Specifically, the facility failed to ensure Resident #83's MDS accurately indicated the resident was receiving hospice services. Findings include: I. Facility policy and procedure The Documentation of Medical Record policy and procedure, undated, was received from the nursing home administrator (NHA) on 1/16/25 at 1:47 p.m. It revealed in pertinent part, Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. II. Resident #83 A. Resident status Resident #83, age 66, was admitted on [DATE]. According to the January 2025 computerized physician's orders (CPO), the diagnoses included chronic obstructive pulmonary disease (COPD) and heart failure. The 11/26/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She was dependent with toileting, personal hygiene, bed mobility and required set up assistance with eating. The assessment indicated Resident #83 was receiving hospice care. -However, review of Resident #83's EMR did not reveal the resident was receiving hospice services (see record review below). B. Record review A comprehensive review of the EMR failed to reveal a physician's order for hospice, progress notes of hospice services or care planned interventions of hospice services being provided. III. Staff interview (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NHA was interviewed by email communication on 1/15/25 at 1:20 p.m. She said the hospice services coded for Resident #83 on the MDS assessment was incorrect and would be corrected. The minimum data set coordinator (MDSC) was interviewed on 1/16/25 at 2:15 p.m. The MDSC said she was responsible for completing the MDS assessments for the residents. The MDSC said she would assess a resident in their room and speak with staff about resident cares to complete the MDS assessment. The MDSC said she double checked the MDS assessment and read through alerts at the end prior to signing it. The MDSC said alerts could come from a new change on the MDS assessment that was different from the previous MDS assessment if it was available. She said if an alert came up, she could change the response at that time. The MSDC said the MDS assessment could be modified at any time if an error was found. The MDSC said Resident #83 was not on hospice services and that was coded in error. The MDSC said that the MDS assessment for Resident #83 had been corrected when it was brought to her attention (during the survey). The MDSC said she planned to slow down when reading through the alerts in the future to ensure that MDS assessments were coded correctly.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47151 Based on observations, record review and interviews, the facility failed to ensure two (#45 and and #95) of five residents who required respiratory care received the care consistent with professional standards of practice out of 53 sample residents. Specifically, the facility failed to: -Implement a routine cleaning schedule for the care of Resident #45's continuous positive airway pressure (CPAP) machine; -Ensure a care plan was in place and implemented for Resident #45's CPAP machine to include route of administration, oxygen supplementation, storage, cleaning and machine settings; and, -Ensure a functional continuous positive airway pressure (CPAP) machine was available, cleansed, stored, and maintained for Resident #45 and Resident #95. Findings include: I. Professional reference The Legionella Toolkit (12/26/24) retrieved on 1/22/25 from the Centers for Disease Control (CDC) https://www.cdc.gov/control-legionella/php/toolkit/control-toolkit.html. It read in pertinent part, In the absence of control, Legionella can grow in almost any system or equipment containing non sterile water, such as tap water, at temperatures favorable to Legionella growth. Devices that may grow Legionella in the absence of control include the following: dental and medical equipment such as scalers, CPAP, bronchoscopes, and heater-cooler units. Dental and medical equipment should be cleaned regularly per manufacturer recommendations and use distilled water in respiratory equipment such as CPAP machines, heater-cooler units, and bronchoscopes (page 8). II. Facility policy and procedure The CPAP policy, revised November 2021, was provided by the nursing home administrator (NHA) on 1/16/25 at 1:47 p.m. The policy read in pertinent part, A CPAP or BiPAP's purpose is to improve oxygenation, assist in reducing pulmonary edema, decrease the work of breathing and for use with residents who do not require assistance in maintaining adequate minute volume. Cleaning the CPAP and BiPAP machines: wash the mask daily in fragrance-free soap, mild and warm water or with designated sanitation wipes, then rinse in warm water and air dry. The frame of the mask should be cleaned weekly in warm soapy water or with a designated sanitation wipe. The CPAP/BiPAP humidifier uses distilled water only and should be emptied and refilled daily. The humidification chamber should be washed daily using mild soap and warm water and air dried. III. Resident #45 A. Resident status (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #45, age greater than 65, was admitted on [DATE]. According to the January 2025 computerized physician orders (CPO), diagnoses included type 2 diabetes, chronic respiratory failure with hypoxia, chronic kidney disease stage 2 and dependence on supplemental oxygen. The 12/3/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident was dependent on assistance with transfers and bed mobility and needed substantial assistance with bathing. He needed set up help with upper body dressing and oral hygiene and was independent at meal time. The MDS assessment documented the resident used a non-invasive mechanical ventilator. B. Resident interview and observation Resident #45 was interviewed on 1/13/25 at 11:05 a.m. Resident #45 said his CPAP machine did not get cleaned at the facility and he used his CPAP every night. Resident #45 said he cleaned his own CPAP machine himself. Resident #45's CPAP mask and tubing were on his nightstand during the interview on 1/13/25. C. Record review A review of Resident #45's January 2025 CPO revealed a physician's order to apply the CPAP at bedtime for sleep with two liters of oxygen bled in, one time a day starting 4/23/23. A review of Resident #45's care plan documented he had altered respiratory status and difficulty breathing related to sleep apnea and had coronary heart failure. Pertinent interventions included the use of the CPAP machine as ordered. -However, further review of the resident's electronic medical record (EMR) revealed Resident #45 did not have a physician's order that included the storage of the machine and/or settings of the device. Additionally, review of the resident's EMR revealed Resident #45 did not have a physician's order for cleaning his CPAP machine. -The use of a CPAP machine was not on Resident #45's care plan as an active problem area, and the care plan did not have goals and interventions listed for the CPAP machine, to include route of administration, frequency, oxygen supplementation, storage and/or settings and a cleaning schedule. IV. Resident #95 A. Resident status Resident #95, age greater than 65, was admitted on [DATE] and readmitted on [DATE]. According to the January 2025 CPO, diagnoses included obstructive sleep apnea (OSA), primary pulmonary hypertension (high lung pressure) and chronic obstructive pulmonary disease (COPD). (continued on next page)

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

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 12/3/24 MDS assessment revealed the resident was cognitively intact with a BIMSscore of 15 out of 15. She required partial assistance with bed mobility. She was dependent on staff for toileting hygiene, lower body dressing, applying/removing footwear, transfers, and locomotion. The assessment indicated the resident used a non-invasive mechanical ventilator. B. Observations On 1/13/25 at 10:26 a.m. Resident #95's CPAP mask and tubing were hanging over the resident's bed rail. The CPAP mask was on the floor. On 1/14/25 at 9:39 a.m. Resident #95's CPAP mask and tubing were hanging over the resident's bed rail. The CPAP mask was on the floor with a floor fan on top of the mask's two straps. On 1/15/25 at 8:10 a.m. Resident #95's CPAP mask and tubing were hanging over the resident's bed rail. The CPAP mask was on the floor with a floor fan on top of one of the mask's straps. On 1/16/25 at 10:38 a.m. Resident 95's CPAP mask was stored in a plastic bag hanging on the resident's bed rail. C. Resident interviews Resident #95 was interviewed on 1/15/25 at 8:10 a.m. Resident #95 said she had not used her CPAP machine in two to three years. She said her CPAP machine was not functional and the power cord had been lost when she moved to a different room in the facility. She said the unit manager (UM) ordered a new power cord one month ago (December 2024) and she was still waiting for it to arrive. Resident #95 was interviewed on 1/15/25 at 9:05 a.m. Resident #95 said her CPAP mask and machine had not been cleaned since she moved in. Resident #95 was interviewed a second time on 1/16/25 at 10:38 a.m. Resident #95 said she contacted her service provider about the power cord for her CPAP machine and she was told they would provide an update at her next appointment. She said she did not use her CPAP machine the previous night (1/15/25) and she thought the UM stored it in a bag on 1/15/25 after he was looking at her machine. D. Record review A physician's order, dated 11/12/24, revealed staff should cleanse Resident #95's CPAP every night with provided cleansing wipes. A physician's order, dated 10/25/24, revealed staff should bleed in two liters of oxygen, then assist Resident #95 with her CPAP machine at bedtime for OSA. The respiratory care plan, initiated on 6/27/23 and revised on 11/4/24, revealed Resident #95 was at risk of respiratory distress due to COPD and OSA. It documented Resident #95 had a CPAP machine and often declined to use it. Interventions included a mask fitting, on 11/5/24, to promote CPAP compliance, administering medications/inhalers as ordered, cleansing and sanitizing Resident #95's CPAP machine with CPAP wipes as directed and monitoring for signs and symptoms of respiratory distress. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurse progress note, dated 11/5/24 at 4:22 p.m., revealed Resident #95's provider was notified she was not using her CPAP machine due to mask fit. It documented a new mask was on order and should come soon. -Review of Resident #95's EMR failed to reveal documentation to indicate the facility had addressed the resident's non-functional CPAP machine or what interventions were put in place to repair/replace it. V. Staff interviews Registered nurse (RN) #1 was interviewed on 1/15/25 at 9:42 a.m. RN #1 said the night nurse was responsible for cleaning and storing the CPAP machines/masks for residents. She said she was unsure how CPAP masks should be stored or how often the tubing should be changed. She said she would find the answer by asking the facility's infection control nurse, respiratory therapist, and/or the UM. The respiratory vendor (RV) was interviewed on 1/15/25 at 10:18 a.m. The RV said the respiratory company provided respiratory equipment for residents' needs. He said he came weekly to the facility to service equipment and replace supplies per schedule or as needed. He said if a resident/family used their personal respiratory equipment, the company would service them upon request and bill whoever initiated the request. The RV said the CPAP mask and tubing should be changed every three months. He said the mask should be stored in a bag or a resident's top nightstand drawer. He said it was important to keep it off of the ground. He said the respiratory company recommended CPAP machine supplies to be cleansed daily. UM #1 was interviewed on 1/16/25 at 11:56 a.m. UM #1 said the night shift nurses were responsible for cleaning residents' CPAP masks daily. He said he needed to check the facility's policy and procedure to verify how often CPAP machines should be cleansed. He said CPAP masks should be stored in plastic bags hung at the resident's bedside and the tubing should be draped over the bed rail. He said he requested a power cord for Resident #95's CPAP machine the previous month (December 2024) during a meeting with her care provider. He said he had left multiple voicemails, without a response or update, and advised Resident #95 to ask her care provider for an update. He said he was unsure if the CPAP mask and tubing in the plastic bag at Resident #95's bedside were new. UM #1 said he would discard the mask and tubing at Resident #95's bedside and replace it. -On 11/16/25 at 12:20 p.m., UM #1 was observed in Resident #95's room. He discarded the CPAP mask and tubing at her bedside. He said he would replace supplies with those from the facility's stock and order additional supplies from Resident #95's care provider. The director of nursing (DON) was interviewed on 1/16/25 at 1:51 p.m. The DON said the night nurses were historically responsible for cleansing CPAP supplies, however, the facility had recently given the UMs the ability to adjust the time cleansing occurred. She said the facility bulk-ordered wipes specifically used to cleanse respiratory supplies. She said the cleansing/maintenance schedule and orders/machine settings were resident-specific, and should be documented in the resident's orders and care plan. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON said she was not sure how often CPAP machines/masks should be cleansed and how often the tubing should be replaced. She said CPAP masks should be stored in a plastic bag hung at the resident's bedside or in a bag in the top drawer of the resident's nightstand. She said she was unaware Resident #95's CPAP machine was non-functional and did not know the length of time since it was last used. The DON said cardiac issues were a potential risk for a resident not using the CPAP machine as ordered and respiratory illnesses were a risk if CPAP masks/machines were not stored and cleansed correctly. 51710

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47350 Based on observations, record review and interviews, the facility failed to ensure that a consent and a safety bed rail evaluation was in place for one (#151) of five residents with bed rails out of 53 residents. Specifically, the facility failed to: -Ensure a signed consent was obtained from Resident #151 or the resident's representative prior to the initiation of side rails; -Ensure a physical therapy or occupational therapy (PT/OT) safety evaluation was conducted for Resident #151 prior to the use of half bed rails on a new bed; -Ensure the least restrictive alternatives were tried and documented prior to the use of half rails; and, -Ensure a physician's order was obtained for Resident #151 prior to the use of bed rails. Findings include: I. Professional reference According to the U. S. Food and Drug Administration (FDA) (2023), Recommendations for Health Care Providers Using Adult Portable Bed Rails, retrieved on 1/22/25 from https://www.fda.gov/medical-devices/adult-portable-bed-rail-safety/recommendations-health-care-providers-using-adult-portable-bed-rails, Avoid the routine use of adult bed rails without first conducting an individual patient or resident assessment. Evaluation is needed to assess the relative risk of using the bed rail compared with not using it for an individual patient. II. Facility policy and procedure The Physical Restraint policy and procedure, revised December 2019, was provided by the nursing home administrator (NHA) on 1/16/25 at 3:12 p.m. It read in pertinent part, Physical restraint is any manual method, or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the resident can not easily remove and that restricts freedom of movement or normal access to his/her body part. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Does a resident have a device that can be considered a restraint? If yes, complete a physical restraint evaluation form, complete the physical restraint elimination usage form if the resident is a candidate for restraint reduction, elimination or usage. Physical therapy/Occupational therapy (PT/OT) consultation for least restrictive physical restraint. Obtain physician's order for restraint including medical symptoms for restraint usage, type of restraint, time of use and duration. Discuss restraint alternatives, risks and benefits with resident or legal representative upon initiation and annually. Complete physical restraint evaluation upon initial use and quarterly or with significant change. Document on care plan. III. Resident #151 A. Resident status Resident #151, age less than 65, was admitted on [DATE]. According to the January 2025 computerized physician orders (CPO), diagnoses included quadriplegia (paralysis of all four limbs) and pressure ulcers. The 10/14/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. He was dependent on staff with toileting, personal hygiene, bed mobility, transfers and required substantial/maximal assistance with eating. The assessment indicated physical restraints, including bed rails were not used. B. Observations and resident interview On 1/13/25 at 2:29 p.m. Resident #151 was lying in bed with two half rails in the up position on the bed. On 1/15/25 at 3:04 p.m. Resident #151 was lying in bed with two half rails in the up position on the bed. On 1/16/25 at 9:22 a.m. Resident #151 was lying in bed with two half rails in the up position on the bed. Resident #151 was interviewed on 1/16/25 at 9:23 a.m. Resident #151 said the nursing staff used the half rails when they were doing wound care in the mornings to prevent him from rolling out and put them down after they were done using them. He said he was able to use the controls on the bed rails to put his head up and down. He said he was not mobile enough to be able to get trapped between the bed rails and the bed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C. Record review The January 2025 CPO revealed a physician's order to put opposite rail for legs up when turning resident in bed and have two people to do any care that required turning in bed, ordered 10/10/24. -However, the physician's order did not indicate that the resident's bed rails were to be in the up position when staff was not repositioning the resident. The 10/30/24 nursing physical restraint evaluation identified the use of half rails needed for positioning and to promote independence. It documented the side rails were not a restraint because the resident was paralyzed. It documented the use of half rails was requested by nursing staff and the resident. -However, Resident #151 was totally dependent on staff for bed mobility and therefore was unable to use the bed rails independently. -However, the evaluation failed to document if a PT/OT screening had been done for the bed rails to assess for safety. The 10/30/24 nursing physical restraint elimination/usage evaluation documented a score of 19 out of 20, which indicated the potential elimination of the restraint and to attempt alternatives for restraint. -However, a comprehensive review of the nursing physical restraint elimination evaluation and Resident #151's electronic medical record (EMR) did not document that potential alternatives to the bed rails had been attempted by the facility or that discussion had taken place regarding the potential elimination of the side rails. The activities of daily living (ADL) care plan, initiated on 10/7/24, indicated Resident #151 was dependent with bed mobility. Interventions included using bed canes to promote independence for repositioning and turning in bed. -However, Resident #151 was totally dependent on staff for bed mobility and therefore was unable to use the bed rails independently. -A comprehensive review of the care plan failed to reveal documentation of the use of bed rails or other least restrictive alternatives. A comprehensive review of Resident #151's EMR failed to reveal documentation of a signed consent, a physical restraint evaluation, a physical restraint elimination evaluation, a PT/OT safety screening or a physician's order prior to the implementation of a new bed and initiation of the half side rails. IV. Staff interviews (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed practical nurse (LPN) #3 was interviewed on 1/16/25 at 9:30 a.m. LPN #3 said bed rails were a physical restraint and should have an evaluation for risk versus benefit. He said the bed rails should be assessed for proper functioning. He said prior to initiating any physical restraint, a consent needed to be obtained and a physician's order. He said Resident #151 had side rails to help prevent falls out of bed during repositioning. He said Resident #151 also used side rails for safety because he had seizures. -However, there was no documentation in Resident #151's EMR to indicate the resident used the bed rails due to seizures. The NHA was interviewed on 1/15/25 at 3:00 p.m. The NHA said Resident #151 should not have half bed rails up on his bed. She said the bed he was using should have the bed rails zip locked down to prevent their use. She said she was not aware that bed rails were being used for Resident #151. Unit manager (UM) #2 was interviewed on 1/16/25 at 10:20 a.m. UM #2 said she was new to the physical restraint evaluation process. She said before bed rails were used, nursing staff should evaluate the need for them, obtain a consent and a physician's order. She said the nursing staff obtained a consent for the use of Resident #151's bed rails on 1/15/25 (during the survey) on the new bed from the resident. She said Resident #151 had been on a different bed with a dolphin mattress (a pressure redistribution specialty air mattress used to treat pressure wounds) and had recently switched to the current hospital type bed with the half bed rails. She said nursing staff used the bed rails to help with repositioning the resident. She said the resident was able to use the control on the bed rails himself. The director of nursing (DON) was interviewed on 1/16/25 at 3:00 p.m. The DON said that any potential restraint should be assessed to determine if it was a true restraint. She said PT/OT was involved in evaluating bed rails. She said there was a restraint assessment done when Resident #151 was admitted to the facility for his bed rails on the old bed. The DON said therapy had determined there was no benefit to having the side rails up and Resident #151 had agreed to having the side rails zip locked down so they could not be used. The DON said there were other things the facility could try for repositioning the resident, including bolsters, that were not bed rails. She said Resident #151's old bed had a dolphin mattress which he did not like. She said it was discovered, during survey, that Resident #151 had arranged for a new bed from the veterans administration (VA) and had it delivered to the facility. She said she and the NHA had not been aware Resident #151 had a new bed delivered and had been using it since approximately November 2024 or December 2024. The DON said therapy had done an evaluation on the new bed for the bed rails, after it was brought to their attention, during the survey. She said it was not a practice of the facility to use bed rails. She said medical equipment, such as hospital beds, should not be brought into the facility and used by staff and residents without notifying the DON and the NHA.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 47151 Based on observations, record review and interviews, the facility failed to ensure residents received food and fluids prepared in a form designed to meet his or her needs in one of five dining rooms. Specifically, the facility failed to ensure residents who were prescribed mechanically altered diets had food prepared according to the resident's diet orders of mechanical soft as indicated on their meal tray cards. Findings include: I. Facility policy and procedure The Therapeutic Diet Orders policy, undated, was provided by the nursing home administrator (NHA) on 1/16/25 at 4:55 p.m. It read in pertinent part, The facility provides all residents with foods in the appropriate form and/or the appropriate nutritive content as prescribed by a physician, and/or assessed by the interdisciplinary team to support the resident's treatment/plan of care, in accordance with his/her goals and preferences. A mechanically altered diet is one in which the texture or consistency of food is altered to facilitate oral intake. Examples include soft solids, pureed foods, ground meat, and thickened liquids. Therapeutic diets, including mechanically altered diets where appropriate, will be based on the resident's individual needs as determined by the resident's assessment. Therapeutic diets may be considered in certain situations, such as, but not limited to: inadequate nutrition, nutritional deficits, weight loss, medical conditions such as diabetes, renal disease, or heart disease and swallowing difficulty. Dietary and nursing staff are responsible for providing therapeutic diets in the appropriate form and/or the appropriate nutritive content as prescribed. II. Meal service observations Meal Service was continuously observed on 1/15/25 from 4:30 p.m. to 6:00 p.m. The posted menu documented the dinner meal as quiche, zucchini and onions, oven roasted potatoes, an apple cinnamon muffin and a fruit cup. At 5:20 p.m. meal tray assembly started for the long hall. A meal ticket indicated a resident was prescribed a mechanical soft diet order. The plate was assembled with a soft shell taco and ground beef, zucchini and potato wedges. The potato wedges served had skin on the potato. The meal tray was placed in the room delivery cart for service. At 5:45 p.m. a meal was assembled for a resident who's meal ticketed documented a mechanical soft diet. Written on the meal ticket was soft taco and sides. The plate was assembled with a soft shell taco and ground beef and potatoes wedges. The potato wedges served had skin on the potato and the plate was delivered to the resident in the dining room. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-However, according to the diet manual description (see below) potato skins were restricted for residents prescribed a mechanically alerted diet. Both plates contained potatoes with the skin on the potatoes. At 5:52 p.m. the human resources director (HRD), who was the previous dietary manager was notified the oven roasted potatoes contained skins and were served to residents on a mechanical soft diet. The HRD said residents on mechanical soft diets should not have potato skins. III. Record review The fall/winter 2024-2025 diet spreadsheets were provided by the NHA on 1/13/25 at 1:00 p.m. The spreadsheet for dinner on 1/15/25 documented oven roasted potatoes could be served to a resident on a mechanical soft diet. -However, according to the diet manual description (see below) potato skins were restricted for residents prescribed a mechanically alerted diet. Both plates contained potatoes with the skin on the potatoes. The Dysphagia Mechanically Altered Diet Consistency Alteration Diet Manual , undated, was provided by the NHA on 1/16/25 at 1:30 p.m. It read in pertinent part, Avoid dry tough meats, or any other whole pieces of meat, cheese slices or cues, peanut butter sandwiches or pizza, potato chips, skins, fried or french fried potatoes. Please pay close attention to the menu extensions provided. Be sure that all planned foods are prepared. It is imperative to post a copy of the current day's menu extension on the tray line for easy reference during meal service. (page 71). The recipe for red fresh oven roasted potatoes, dated 11/7/23, was provided by the NHA on 1/16/25 at 1:30 p.m. The recipe instructions documented the following production steps: 1. Cut the red potatoes into quarters and steam or boil until tender. Drain off the excess liquid. 2. Melt the margarine with garlic and salt and toss the potatoes with seasoned margarine. Bake in the oven at 400 degrees fahrenheit (F) for 35 to 40 minutes or until lightly browned and tender. Hold or serve hot food at or above 135 degrees F. -The recipe did not include any further instructions on how to modify red fresh oven roasted potatoes for mechanically altered diets. IV. Staff interviews The HRD was interviewed on 1/15/25 at 5:56 p.m. The HRD said she was not sure what happened but the potatoes sent and served to the other dining rooms in the building all had potatoes without skins. She said she brought the potatoes without skins to the first floor dining room for service and removed the roasted potatoes with skin from the steam table. The dietary manager (DM) and the NHA were interviewed together on 1/16/25 at 11:30 a.m. The DM said the speech therapy department reviewed food items the residents could or could not have. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NHA said she spoke to the speech therapist for the facility. The NHA said she asked the speech therapist if they had reviewed the recipe for the oven roasted potatoes, and the speech therapist replied to the NHA that residents on a mechanical soft diet could have potato skins. The NHA said she requested a resource from the speech therapist that indicated a resident on a mechanical soft diet was able to have potato skins. -However according to the facility's diet manual (see above) potato skins were restricted from the mechanical soft diet.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47151 Based on observations, record review and interviews, the facility failed to ensure food was prepared, distributed and served under sanitary conditions in five of five nourishment refrigerators. Specifically, the facility failed to ensure safe and appropriate storage of food items in the nourishment refrigerators. Findings include: I. Professional reference The Colorado Retail Food Establishment Regulations, ([DATE]), retrieved on [DATE], read in pertinent part, Ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 41 degrees fahrenheit (F) or less for a maximum of seven days. The day of preparation shall be counted as day one. The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety. (Chapter ,d+[DATE]). The Hormel Handling Information product guide, (2025), retrieved on [DATE], read in pertinent part: For Med-Pass products: Shelf life is up to four days refrigerated after opening. (Page 5) II. Facility policy and procedure The Safe Handling of Foods From Visitors policy, undated, was provided by the nursing home administrator (NHA) on [DATE] at 1:00 p.m. The policy read in pertinent part, Facility staff will request that visitors bringing in food, and or residents that received food, must notify a member of the nursing or activities departments. The responsible facility staff member will determine whether the food item is for immediate consumption or to be stored for later use. When food items are intended for later consumption, the responsible facility staff member will. Ensure that the food is stored separate or easily distinguishable from the facility food in a unit refrigerator/freezer or resident's personal regenerator in their room and labeled with the resident name and current date. Refrigerators/freezer storage of foods brought in by visitors will be properly maintained and equipped with thermometers, have temperatures monitors daily for refrigerators equal to or less than 41 degrees fahrenheit and equal to or less than ten degrees fahrenheit; daily monitoring for refrigerated storage duration and discard of any food items that have been stored for more three or more days; and cleaned weekly. III. Observations On [DATE] at 9:52 a.m. a refrigerator was observed on the first floor behind the nurses station. The refrigerator contained a container of Med-Pass (liquid supplement) approximately a quarter full and an unopened Monster energy drink. A sticky light brown substance with long black hair was in the bottom of the refrigerator. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The facility failed to label the Med-Pass with an opened or expiration date according to the product's handling instructions (see recommendations above) and the Monster energy drink was not labeled with a resident's information to differentiate it from the staff's food. On [DATE] at 10:04 a.m. a refrigerator was observed in the second floor dining room. The refrigerator contained a container of Med-Pass approximately a quarter full. -The facility failed to label the Med-Pass with an opened or expiration date according to the products' handling instructions (see recommendations above). On [DATE] at 10:09 a.m. a refrigerator was observed on the third floor. The refrigerator contained three Nestle Boost supplements with a use by date of [DATE]. On [DATE] at 10:22 a.m. in the first floor secure unit freezer, there was a clear plastic one ounce (oz) medication cup with a frozen white substance in the cup. There were small light pink pieces on top of the white substance with a small white spoon frozen inside the cup. The cup was not labeled or covered. On [DATE] at 10:35 a.m. a refrigerator was observed on the third floor secure unit. The refrigerator contained the following: -A container of Med-Pass approximately a quarter full and the facility failed to label the Med-Pass with an opened or expiration date according to the product's handling instructions (see recommendations above). -A clear plastic container topped with a red lid that contained fresh blueberries was not labeled with a resident's name or date on the container. -An opened, two quart container of coffee mate creamer that was not labeled with a resident's name or expiration date on the container. -One 16 ounce pump bottle of hand sanitizer. -A clear, two quart plastic container of salsa with no resident's name or expiration date on the container. -A disposable Starbucks cup with a sticker dated [DATE] at 9:11 a.m. with no residents name on the cup -One can of unopened Red Bull that was not labeled to differentiate it from the staff's food. A typed sign was posted on the refrigerator that read in pertinent part: Residents only. All items must have a resident name and date. All employee items will be removed. IV. Staff interviews (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dietary aide (DA) #1 was interviewed on [DATE] at 10:05 a.m. DA #1 said a resident's family member could bring and keep a resident's food in the nourishment refrigerator. DA#1 said she asked the family to put the resident's name, room number and date on the item. DA #1 said the nurses used Med-Pass and should label the Med-Pass container upon opening it. Certified nurse aide (CNA) #5 was interviewed on [DATE] at 1:00 p.m. CNA #5 said if a resident's family brought in food and asked facility staff to store the food, CNA #5 labeled the container with the date food was brought to the facility and then placed the food in the resident's refrigerator. CNA #5 said if a family brought in food that was placed in a nourishment refrigerator at the nurses station she would label the item with the resident's name also. The NHA and the director of nursing (DON) were interviewed together on [DATE] at 11:30 a.m. The NHA said the dietary staff monitored temperatures of the nourishment refrigerators and checked for expired products . The NHA said the nursing staff used the refrigerators as well. The NHA said the nursing staff and the dietary staff could remove expired items from the refrigerators. The DON said the Med-Pass was not a widely used supplement but the containers were usually placed in the refrigerators after being opened. The NHA said a staff drink or food in a resident refrigerator would be discarded because the nourishments refrigerators were for resident food only.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47151 Based on observations, record review and interviews, the facility failed to implement their policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling and consumption on two of three floors. Specifically, the facility failed to ensure safe and appropriate storage of food items in resident's personal refrigerators. Findings include: I. Professional reference The Colorado Retail Food Establishment Regulations, (3/16/24), retrieved on 1/21/25 read in pertinent part: Ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 41 degrees Fahrenheit (F) or less for a maximum of seven days. The day of preparation shall be counted as day one. The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety. (Chapter 3-28). II. Facility policy and procedure The Safe Handling of Foods From Visitors policy, undated, was provided by the nursing home administrator (NHA) on 1/13/25 at 1:00 p.m. The policy read in pertinent part, Facility staff will request that visitors bringing in food, and or residents that received food, must notify a member of the nursing or activities departments. The responsible facility staff member will determine whether the food item is for immediate consumption or to be stored for later use. When food items are intended for later consumption, the responsible facility staff member will: Ensure that the food is stored separate or easily distinguishable from the facility food in a unit refrigerator/freezer or resident's personal regenerator (sic) in their room and labeled with the resident name and current date. Refrigerators/freezer storage of foods brought in by visitors will be properly maintained and equipped with thermometers, have temperatures monitors daily for refrigerators equal to or less than 41 degrees fahrenheit and equal to or less than ten degrees fahrenheit; daily monitoring for refrigerated storage duration and discard of any food items that have been stored for more three or more days; and cleaned weekly. III. Observations On 1/13/25 at 11:00 a.m. the following observations were made in room [ROOM NUMBER]: Two personal refrigerators each belonging to the residents who resided in room [ROOM NUMBER] were inspected. One refrigerator contained two packages of cheese and two containers of meat were stored in the refrigerator. The refrigerator did not have an internal thermometer. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A resident who resided in room [ROOM NUMBER] was interviewed and said facility staff did not check the temperature of her refrigerator but her husband checked the refrigerator daily and kept it clean. The second personal refrigerator in room [ROOM NUMBER] was inspected and did not have an internal thermometer. On 1/13/25 at 1:40 p.m. the personal refrigerator in room [ROOM NUMBER] far was inspected and did not have an internal thermometer. IV. Record review Personal refrigerator monitoring logs from December 2024 (12/1/24 to 12/31/24) and January 2025 (1/1/25 to 1/13/25) were reviewed. On 12/23/25, there were no temperatures recorded for refrigerators in room [ROOM NUMBER], #131, #133, #134, #135, #137, #138 or the two refrigerators in room [ROOM NUMBER]. Temperatures were recorded once daily each day on 12/5, 12/26, and 12/27/25 for residents personal refrigerators and were as follows: A refrigerator in room [ROOM NUMBER] was documented as having temperatures of 42 F, 42 F, and 44 F. A refrigerator in room [ROOM NUMBER] was documented as having a temperature of 42F, 45, and 41 F. A refrigerator in room [ROOM NUMBER] was documented as having temperatures of 41 F, 45 F and 44 F. A refrigerator in room [ROOM NUMBER] was documented as having temperatures of 41 F, 43 F, and 43 F. A second refrigerator in room [ROOM NUMBER] was documented as having temperatures of 42 F, 41 F, and 44 F. -However, neither refrigerator in room [ROOM NUMBER] was labeled to indicate which resident's refrigerator was being monitored or what corrective actions were taken when the temperatures were out of range. Temperature logs for 1/13/25 through 1/16/25 revealed the following: A refrigerator in room [ROOM NUMBER] was documented once daily as having a temperature of 45 F, 45 F, 45 F and 45 F each day. A refrigerator in room [ROOM NUMBER] was documented once daily as having a temperature of 43 F, 43 F, 43 F, 43 F each day. -However, corrective actions were not indicated for the refrigerators in rooms #355 and #358 when they were documented as having temperatures out of the acceptable range. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	V. Staff interviews Certified nurse aide (CNA) #5 was interviewed on 1/15/25 at 1:00 p.m. CNA #5 said she was not sure who monitored the temperatures of the resident's personal refrigerators. CNA #5 said if a resident's family brought in food and asked facility staff to store the food, she labeled the container with the date food was brought to the facility and then placed the food in the resident's refrigerator. The NHA was interviewed on 1/16/25 at 11:00 a.m. The NHA said the housekeeping staff monitored and recorded the temperatures of resident's personal refrigerators when the rooms were cleaned. The NHA said the housekeeping staff kept a binder of all temperature logs for the residents personal refrigerators. The NHA said she was unsure if the facility staff provided education to the residents or their representatives regarding the food from outside sources policy. The NHA said she talked to the residents and families about the appropriate plugs and placement of the refrigerators. The environmental services director (ESD) and the NHA were interviewed together on 1/16/25 at 1:00 p.m. The ESD said each housekeeper brought a refrigerator monitoring log with them when they cleaned the resident's room. The ESD said there was a monitoring log for each hallway and when a housekeeper cleaned a resident's room, the personal refrigerator was checked and the temperature of the resident's personal refrigerator was recorded on the log. The ESD said if the temperature was above 40 degrees fahrenheit on the thermometer, that meant the refrigerator's temperature was out of range and the housekeeping staff should inform her. The ESD said she recently ordered thermometers and gave them to housekeeping staff on 1/15/25 to replace any refrigerators that needed them. The ESD said housekeeping staff carried extra thermometers with them. The NHA said if a resident's personal refrigerator was out of temperature range the facility would replace the refrigerator and discard the perishable food from the room. 51710 VI. Resident interviews and observations The resident who resided in room [ROOM NUMBER] was interviewed on 1/13/25 at 10:29 a.m. The resident said she had lived in the facility for two years and her refrigerator had not been cleaned since she moved in. The refrigerator in room [ROOM NUMBER] was observed. The refrigerator had a small amount of food spills that were red and brown in color and the freezer was half-full of packed ice crystals. A thermometer was found inside that read 40 degrees. Temperature logs were not seen in Resident #66's room. room [ROOM NUMBER]'s refrigerator was observed again on 1/15/25 at 8:09 a.m. The refrigerator had one wrapped, undated, dessert inside. The refrigerator had a small amount of food spills that were red and brown in color and the freezer was half-full of packed ice crystals. The thermometer inside read 42 degrees. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The refrigerator in room [ROOM NUMBER] was observed on 1/13/25 at 10:15 a.m. The refrigerator did not have a thermometer inside. There were two open, undated, cups of fluids inside the refrigerator. The refrigerator had a small amount of food spots that were brown in color and had some built up ice-crystals present. The refrigerator in room [ROOM NUMBER] was observed again on 1/15/25 at 8:19 a.m. The refrigerator had a small amount of food spots that were brown in color. There was not a thermometer inside the refrigerator. The freezer had some built-up ice crystals present.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47151 Based on record review and interviews, the facility failed to maintain accurately documented medical records for one (#114) of four residents out of 53 sample residents. Specifically, the facility failed to ensure Resident #114's wound orders and treatment records were accurate. Findings include: I. Facility policy and procedure The Documentation of Medical Record policy, undated, was provided by the nursing home administrator (NHA) on 1/16/25 at 4:30 p.m. It read in pertinent part, Licensed staff and interdisciplinary team members shall document all assessments, observations and services provided in the resident's medical record in accordance with state law and facility policy. Documentation may be performed manually or as per the facility's specific electronic medical record software program. Principles of documentation include but are not limited to: Documentation shall be factual, objective and resident centered; documentation shall be accurate, relevant and complete, containing sufficient details about the residents' care and/or responses to care; documentation shall be timely and in chronological order. Record date and time of entry. When documentation occurs after the fact, outside of acceptable time limits, the entry shall be clearly indicated as' late entry.' Corrections to a medical record shall be made to clarify inaccurate information. Contradictory information may be clarified by a new entry in the medical record. II. Resident status Resident #114, age greater than 65, was admitted on [DATE]. According to the January 2025 computerized physician orders (CPO), diagnoses included post surgical aftercare of the skin and subcutaneous tissue and multiple pressure ulcers. The 11/18/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. He was dependent on total assistance from staff for toileting hygiene and lower body dressing, needed substantial assistance with bed mobility and bathing, supervision with personal hygiene and set up help only for eating. The MDS assessment documented the resident had one or more pressure ulcers. III. Record review A review of Resident #114's electronic medical record (EMR) revealed the following: A 12/11/24 admission nursing data collection documented in the skin assessment section documented to See wound note. A corresponding note in the resident's EMR documented a skin assessment was completed by the wound nurse, see wound note. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-However a skin/wound was not documented until 12/17/24 (see below). A skin/wound note documented on 12/17/24 revealed wound assessments were completed for Resident #114 on 12/13/24, upon admission. The note documented a right upper buttock unstageable pressure injury. A skin/wound note documented on 12/19/24 revealed a left buttock unstageable pressure injury (corrected from previously documented right buttock). A review of Resident #114's treatment administration record (TAR) revealed treatment orders for a right upper buttock pressure ulcer started 12/12/24 and discontinued 1/13/25. The treatment administration record documented treatment was administered or attempted to be administered as ordered on the right buttock during this time. -However, the facility failed to update Resident #114's wound treatment orders until 1/13/25 (during the survey) to indicate Resident #114 had a left buttock wound instead of a right buttock wound. Resident #114's admission wound location chart was provided by the NHA on 1/14/25 at 1:38 p.m. The wound location chart documented Resident #114 had a wound on his right buttock and no wound on his left buttock. The wound location chart was not dated. -However, the resident's wound was on his left buttock (see interview below). IV. Staff interviews The director of nursing (DON) was interviewed on 1/16/25. The DON said she talked to the two nurses who primarily performed Resident #114's wound treatments. The DON said both nurses knew Resident #114's wound was on his left buttock and not his right buttock. The DON said the nurses did not recognize Resident #114's wound treatment orders were incorrect. The DON said she did provide education to the assistant director of nursing (during the survey) on correct wound documentation in the resident's EMR.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 47064 Based on record review and interviews, the facility failed to provide training to their staff that at a minimum educates staff on activities that constitute abuse, neglect, exploitation and misappropriation of resident property as set forth, procedures for reporting incidents of abuse, neglect, exploitation or misappropriation of resident property and resident dementia abuse prevention. Specifically the facility failed to: -Provide annual resident abuse prevention training/education to 46 out of 212 staff members; and, -Provide annual dementia management education/training for 42 out of 212 staff members. Findings include: I. Facility policy and procedure The Abuse Prevention policy and procedure, revised 12/17/18 was received from the nursing home administrator (NHA) on 1/13/25 at 1:10 p.m. It revealed 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. Residents will not be subjected to abuse by anyone including, but not limited to, facility staff, other residents, consultants or volunteers, staff or other agencies serving the resident, family members or legal guardians, friends or other individuals. Educating staff on factors related to dementia care and abuse prevention, such as understanding that expressions or indications of distress of residents with dementia are often attempts to communicate an unmet need, discomfort or thoughts that they can no longer articulate with words. However, they may be perceived as challenging behaviors to staff and could increase the risk of resident abuse and neglect. II. Staff training records A request was made for the facility's annual abuse and dementia training records for all active staff members on 1/14/25. On 1/15/25 at 3:32 p.m. the staff development coordinator (SDC) provided the records for all active staff members who had completed annual abuse and dementia training. The records revealed 46 out of 212 staff members had not completed the facility's annual abuse training. Additionally, the records revealed 38 out of 212 staff members had not completed the facility's annual dementia training. (continued on next page)

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/16/25 at 2:35 p.m. the NHA provided a revised copy of all active staff members training records for annual abuse and dementia training (see NHA interview below). The revised records revealed 42 (not 38) of 212 staff members had not completed the facility's annual dementia training. -The facility failed to ensure all active staff members completed the annual training for abuse and dementia. III. Staff interviews The NHA was interviewed on 1/15/25 at 3:13 p.m. The NHA said the facility had acquired a new SDC in May 2024 who was also the infection preventionist (IP) due to the facility identifying issues with training completion. The NHA said the facility put a performance improvement plan (PIP) in place for human resources. However, the NHA said the PIP did not include annual abuse and dementia education. The NHA said the electronic education platform previously used by the facility was not being completed by staff and they had opted into a new training platform that was started on 1/1/25. The NHA said it was important to ensure all staff members were able to provide care and be aware of signs of abuse and dementia care. The NHA was interviewed a second time on 1/16/25 at 12:45 p.m. The NHA said the staff were reviewing employee files to ensure accurate counts for training were given. She said the facility would not be able to provide documentation for all staff members for abuse and dementia training. The NHA said moving forward the SDC would be responsible for auditing and ensuring all abuse and dementia training was completed on hire and annually and it was to be added to the new hire checklist. On 1/16/25 at 3:20 p.m. the director of nursing (DON) was interviewed. The DON said abuse and dementia training for all employees was important for safety and knowledge of how to handle resident situations that could arise, especially with dementia residents in the facility.