STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065379	A. Building B. Wing	12/08/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews, the facility failed to prevent an accident for one (#12) of six residents out of 22 sample residents. Specifically, the facility failed to ensure certified nurse aide (CNA) #4 transferred Resident #12 appropriately, which resulted in a fall for the resident.Findings include:I. Facility policy and procedureThe Fall Risk Assessment and Management policy, revised 9/24/25, was provided by the nursing home administrator (NHA) on 10/8/25 at 3:00 p.m. The policy read in pertinent part, The nursing staff, in conjunction with the attending physician, consultant pharmacist, therapy staff, and others, will seek to identify and document resident risk factors for falls and establish a resident-centered falls prevention plan based on relevant assessment information. Identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling.II. Resident #12A. Resident statusResident #12, age [AGE], was admitted on [DATE] and re-admitted on [DATE]. According to the October 2025 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease (COPD), wedge compression fracture of the first lumbar vertebrae, displaced fracture of the lateral malleolus of the right fibula, age-related osteoporosis, dementia with mood disturbance, left hemiplegia and diabetes mellitus type 2. The 7/18/25 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired with a brief interview for mental status (BIMS) score of four out of 15. She required a Sara lift (mechanical lift) with two-person assistance for transfers, assistance on and off the toilet, and with clothing management, and she turned side to side in bed with staff assistance.B. Record reviewThe 8/5/25 incident report documented Resident #12 was being transferred from her bed to a wheelchair by CNA #4, who was unable to complete the transfer, which caused the resident to fall. As a result of the incident, Resident #12 sustained a 7 centimeter (cm) skin tear to the left lower leg, with active bleeding noted at the time of assessment. According to the incident report, a predisposing factor was gait imbalance, and CNA #4 was unaware that the resident needed a Hoyer lift and assistance from an extra person for transfers.The 8/8/25 recapitulation of events revealed that Resident #12 refused to be transferred with the Sara lift and requested a stand pivot transfer. CNA #4 performed the stand pivot transfer which led to the fall.The activities of daily living care plan, initiated 2/16/21, documented Resident #12 had impaired physical mobility due to left-sided hemiplegia and contracture of the left hand following a stroke. She required a Sara lift and two-person assistance for transfers and used a wheelchair for mobility. The 8/5/25 progress note, documented after the incident, revealed Resident #12 sustained an approximately 7 cm skin tear located on the anterior left lower leg with active bleeding noted at the time of assessment. The surrounding skin was thin and bruised. Resident #12 was oriented and denied pain or dizziness. The nurse on duty assessed the wound, and the staff reported the incident to the resident's physician and family, as well as to the unit manager.III. Staff interviewsCNA #5 was interviewed on (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065379	A. Building B. Wing	12/08/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/7/25 at 4:22 p.m. CNA #5 said the staff were sup the resident with two people using the Hoyer lift. CNA #5 said after the fall on 8/5/25, Resident #12 got a skin tear. CNA #5 said the NHA regularly organized meetings with staff to discuss accident prevention. CNA #4 was interviewed via phone on 10/8/25 at 12:40 p.m. CNA #4 said she was a new employee and before the incident with Resident #12, a registered nurse (RN) told her that Resident #12 was a one-person assistance and was able to stand up and pivot.CNA #4 said she tried to stand-pivot Resident #12 but the resident fell. CNA #4 said after the incident, two staff members came to help, and they put the resident in bed using a Hoyer lift. She said the RN took care of the bleeding on the resident's left leg. CNA #4 said she did not know anything about Resident #12 prior to transferring the resident and she did not take care of the resident after the incident on 8/5/25.RN #2 was interviewed on 10/8/25 at 10:05 a.m. RN #2 said she did not remember anything else about Resident #12's fall because it happened months ago. She said nurses should communicate changes in care plans and transfer statuses to CNAs during rounds.The director of nursing (DON) was interviewed on 10/8/25 at 3:20 p.m. The DON said the best way to determine how to transfer a resident was a multidisciplinary decision between previous facilities' orders, physical therapy (PT) and nursing. The DON said that the statuses for transfers and mechanical lift assistance were in the residents' care plans; however, CNAs did not have access to the entire care plan. She said CNAs could see what they needed to know for resident care or ask a nurse if they needed further information on a resident's transfer status. The DON said CNA #4 transferred Resident #12 by herself because the resident refused the mechanical lift, which caused the resident to fall and sustain a skin tear. The DON said CNA #4 did not ask the nurse how to perform the resident's transfer. The DON said she did not know that an RN told CNA #4 that Resident #1 was a one-person assist for transfers and was able to stand up and pivot. The DON said after the incident, personalized education was provided to CNA #4.The NHA was interviewed on 10/8/25 at 4:30 p.m. The NHA said CNA #4 and the RN on duty at the time of the incident received safe transfer education after the incident. The NHA said she told CNA #4 and the RN that if a resident refused to use a mechanical lift, they needed to communicate with PT because PTs were the only ones allowed to transfer residents without using a Hoyer lift if the resident required a mechanical lift.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065379	A. Building B. Wing	12/08/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure two (#19 and #18) of nine residents reviewed for medication management were free from significant medication errors out of 22 sample residents.Resident #19 was admitted to the facility on [DATE] with diagnoses of dementia with behavioral disturbance, respiratory failure, peripheral vascular disease, and thrombocytopenia (a deficiency of platelets in the blood). On 8/21/25 at 6:38 p.m. Resident #19 was sent out to the emergency department from the facility due to an acute change of condition. Resident #19 was found to have low blood pressure, a decrease in responsiveness, an increase in lethargy and was unable to follow the nursing staff's commands. While at the hospital, it was documented Resident #19 suffered an accidental medication overdose after she was given another resident's medications. It was documented the resident received amlodipine (used to treat high blood pressure), metoprolol (used to relax blood vessels and slow heart rate), hydralazine (used to treat high blood pressure), and oxycodone (a narcotic pain medication). Resident #19 was administered 2 milligrams (mg) of Narcan (a medication used to reverse opioid overdose) by the paramedics, and was awake and had spontaneous respirations afterwards.Additionally, Resident #18 was administered his roommate's medications on 9/21/25.Specifically, the facility failed to:-Ensure Resident #19 did not receive another resident's (Resident #26) medications, which required transfer to the hospital for treatment; and,-Ensure Resident #18 did not receive another resident's (Resident #16) medications.Findings include:Record review and interviews confirmed the facility corrected the deficient practice prior to theonsite investigation from 10/7/25 through 10/8/25, resulting in the deficiency being cited as past noncompliance with a correction date of 9/22/25.I. Medication errors on 8/21/25 and 9/21/25The facility failed to ensure a licensed nurse administered medications to the correct resident.Resident #19 was administered another resident's (Resident #26) medications, which caused the resident to experience a change in condition and the resident was sent to the hospital for treatment. Additionally, Resident #18 was administered Resident #16's medications which led to a change in condition on 9/21/25.II. Facility's plan of correctionThe corrective action plan the facility implemented in response to Resident #19 and Resident #18's medication error incidents on 8/21/25 and 9/20/25 was provided by the nursing home administrator (NHA) 10/8/25 at 4:07 p.m.The stated purpose of the plan was to address the significant medication errors and prevent any additional residents from suffering any adverse outcome.The plan revealed the following:A. Identification of other residentsAn audit of all residents was conducted to ensure an updated photo was present in the electronic medical record (EMR). New, updated photos were uploaded to each resident's EMRs, which was completed by 9/22/25.B. Systemic changesAll applicable facility policies and procedures were reviewed and revised.The assistant director of nursing (ADON) reeducated licensed nurses on the facility's policies regarding medication administration and medication error reporting. All nursing staff were educated prior to working their next shift, completed 9/22/25.The NHA did not allow the two agency nurses who improperly administered medications causing the significant medication errors to return to the facility. The NHA hired seven new nurses to the facility staff to decrease the facility's use of agency staff. The NHA limited agency staff usage to only agency staff members who had worked consistently with the facility in the past, and reviewed the licenses and competencies of each agency staff member prior to their next shift at the facility.C. MonitoringThe director of nursing (DON) or designee would observe medication administration two times per day for four weeks before evaluating to see if additional observations were needed or if the frequency of observations could be decreased at that time. Observations would occur across shifts and with various staff members, including agency staff members.Monthly (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065379	A. Building B. Wing	12/08/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	medication audits were also initiated and were ongoing.The NHA implemented a performance improvement plan as a means to gather and process information from the audit. Findings would be reported at the monthly quality assurancemeetings.The facility's determined date of compliance was 9/22/25.III. Professional referenceAccording to [NAME], P.A., [NAME], A.G et.al,, Fundamentals of Nursing, 10th ed., Elsevier, St.[NAME], Missouri, pp. 606-607, Take appropriate actions to ensure the patient receivesmedication as prescribed. To prevent medication errors, follow the seven rights of medicationadministration consistently every time you administer medications:1. The right medication2. The right dose3. The right patient4. The right route5. The right time6. The right documentation7. The right indication.IV. Facility policy and procedureThe Medication Administration policy, revised 10/3/25, was provided by the NHA on 10/8/25 at 3:58 p.m. It read in pertinent part, Medications are administered in accordance with prescriber orders, including any required time frame. The individual administering medications verifies the resident's identity before giving the resident his/her medications. The individual administering the medication checks the label to verify the right resident, right medication, right dosage, right time and right method of administration before giving the medication.V. Resident #19A. Resident statusResident #19, age [AGE], was admitted on [DATE]. According to the October 2025 computerized physician orders (CPO), diagnoses included dementia with behavioral disturbance, respiratory failure, peripheral vascular disease, and thrombocytopenia.The 7/3/25 minimum data set (MDS) assessment indicated the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The assessment documented the resident needed substantial assistance or was dependent on staff for most activities of daily living (ADL).B. Resident interviewResident #19 was interviewed on 10/8/25 at 1:35 p.m. Resident #19 said she had to go to the hospital four weeks prior to the date of the interview. Resident #19 said she was given a medication cup around a mealtime the day she had to go to the hospital (8/21/25). Resident #19 said when the nurse who gave her the medication cup walked out of the room, the resident realized the medication cup did not have her name on it. Resident #19 said she approached the nurse and tried to tell her it was not her correct medications, but the nurse insisted it was. Resident #19 said she eventually gave up and took the medications in the cup, and immediately began feeling dizzy. Resident #19 said her roommate called the nursing staff to get her help. Resident #19 said she was taken to the hospital, where a doctor flushed out her stomach. Resident #19 said it was difficult to talk about the incident and began to tear up.C. Record reviewThe October 2025 CPO revealed Resident #19 had physician's orders for the following daily scheduled medications: atorvastatin (used to treat high cholesterol) 40 mg, cranberry oral tablets (used to prevent urinary tract infections) 425 mg, duloxetine (an antidepressant) 40 mg, famotadine (used to treat acid reflux) 10 mg, lubiprostone (used to treat gastroesophageal reflux disease) 8 and 24 micrograms (mcg), vitamin D oral tablets 1250 mcg, carvedilol (used to treat high blood pressure) 6.25 mg, apixaban (blood thinner) 5 mg, oxycodone (opioid pain medication) 5 mg, oyster shell calcium (supplement used to treat osteoarthritis) 500 mg, Seroquel (an atypical antipsychotic medication primarily used to treat schizophrenia and bipolar disorder) 12.5 mg, and acetaminophen (anti-inflammatory pain medication) 1000 mg.-Resident #19 did not have physician's orders for amlodipine, metoprolol or hydralazine, the medications she was administered on 8/21/25.A progress note, dated 8/21/25 at 3:21 p.m., revealed Resident #19 was noted to have increased lethargy and slurred speech. Resident #19's vital signs were assessed, and her blood pressure was documented as 98/58 millimeters of mercury (mmHg). Resident #19 said she felt like she took a sleeping pill. The nurse called Resident #19's physician to inform her of the situation and did not receive any new orders at that time. The nurse documented she would continue to monitor the resident and call the physician back (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065379	A. Building B. Wing	12/08/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	with any changes.A progress note, dated 8/21/25 at 4:00 p.m., revealed the nurse observed Resident #19 in bed with her eyes closed. Resident #19 was not easily awakened by touch or by calling her name, but was easily aroused with a sternal rub (a painful stimulus used by medical professionals to test an unconscious person's responsiveness by rubbing the knuckles firmly on the center of the breastbone (sternum). When the nurse asked Resident #19 if she wanted to go to the hospital, Resident #19 was not able to answer clearly and moaned the word no with her eyes remaining closed. Resident #19 was not able to follow the nurse's verbal commands. Resident #19's vital signs were assessed, and her blood pressure was documented as 98/64 mmHg. Resident #19 had received her scheduled medications that morning and had tolerated them well, with her blood pressure that morning documented as 129/75 mmHg. No other sedatives or pain medications were administered during the nurse's shift. A progress note, dated 8/21/25 at 6:38 p.m., revealed the nurse called to notify Resident #19's physician about a change in condition for the resident. Resident #19 continued to have low blood pressure, a decrease in responsiveness, an increase in lethargy and was unable to follow commands. Resident #19 was sent out via emergency medical services to the hospital.Hospital notes, dated 8/22/25, revealed Resident #19 presented to the hospital somnolent (lethargic), apneic (state of respiratory depression) and hypoxic (having insufficient oxygen) after she was given another resident's medications at the facility. Resident #19, in addition to her usual daily medications, received 10 mg amlodipine, 100 mg metoprolol, 75 mg hydralazine and 10 mg of additional oxycodone. Resident #19 was administered 2 mg of Narcan and awoke and began having spontaneous respirations. On exam, Resident #19 was drowsy but awoke easily to verbal stimuli. Resident #19 was monitored and did not have any further complications. Resident #19 was discharged from the hospital back to the facility on 8/22/25 with the primary diagnosis of accidental overdose.A social services note, dated 8/22/25 at 4:21 p.m., revealed the facility's social worker met with Resident #19. Resident #19 said she was happy to be back, and said she knew the person who caused an error in her medication would never come back to the facility.The facility investigation, dated 8/22/25, was received from the NHA on 10/8/25 at 10:26 a.m. and revealed the following:A statement from the nurse on duty that day documented that on 8/21/25 a medic from the emergency medical services called the facility to update them on Resident #19's status. The medic said they had administered Narcan and Resident #19 became responsive afterward. Resident #19 told the paramedics that she had taken a cup of pills on her bedside table and had seen another cup of pills and took them as well. Resident #19 said she realized when she put the cup down, it had Resident #26's name on it. The nurse documented that she had asked the nurse administering medications multiple times if she needed help, which the nurse denied each time. The nurse documented Resident #26 did not receive her morning medications until close to 1:00 p.m. on 8/21/25.Resident #19 was interviewed on 8/22/25 at 12:15 p.m. Resident #19 said she was in her room around breakfast time and a nurse came in and gave her her medications. Resident #19 said she looked at the medications and they did not look like the ones she usually took. Resident #19 said she looked at the medication cup and it had another resident's (Resident #26) name on it. Resident #19 said she tried to call the nurse back into her room but was unable to do so. Resident #19 said she went to her roommate to try to have her look at the cup to see if she was reading the name correctly, but her roommate was unable to read what was written on the cup. Resident #19 said she went to the nurse's medication cart to ask the nurse if the medications were hers. Resident #19 said the nurse looked at her computer and said the medications were for Resident #19. Resident #19 asked multiple times, and the nurse insisted multiple times the medications were hers. Resident #19 felt she either had to take the medications in the cup or not take any medications, so she decided to take them. Resident #19 said around lunchtime that day (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065379	A. Building B. Wing	12/08/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	(8/21/25) she began feeling weird and foggy, and kept drifting off to sleep. Resident #19 said someone had to hold her up so she would not fall out of her wheelchair. Resident #19 said she did not know how some people could take so many medications.Resident #26 was interviewed on 8/22/25 at 12:00 p.m. Resident #26 said she had not received her scheduled morning medications until almost 1:00 p.m. on 8/21/25. Resident #26 said she had to ask the nurse for her morning medications before she received them, and once requested the agency nurse promptly came in to administer her medications.All facility nursing staff were in-serviced on medication administration policy and procedure starting 8/23/25 and ending 8/24/25.D. Staff interviewsRegistered nurse (RN) #1 was interviewed on 10/8/25 at 9:42 a.m. RN #1 said the process for medication administration involved looking at the medication administration record (MAR) to see what medications were due for a resident, gathering the medications for that resident and cross-checking the resident's name in the EMR, medication, dose, route, and the expiration date of the medication. RN #1 said she used the five medication rights when administering medications. RN #1 said when administering medications, she asked the resident to identify themselves before giving them their medications. RN #1 said if the resident could not identify themselves, she referenced the resident's photo and room number listed on the EMR to verify the resident's identity, or used another staff member to verify the resident's identity. RN #1 said all of the photos in the facility's EMR system had been updated within the last two months to ensure the photos accurately reflected the resident's appearance. RN #1 said she had received additional training on the five rights of medication administration two weeks prior (September 2025), as there had been some confusion with medication administration.RN #1 said it was important to ensure she had the correct resident, as someone could accidentally administer the resident's medications to their roommate. RN #1 said if a medication error occurred, she needed to immediately notify the resident's physician with the medications the resident received. RN #1 said the physician would be able to tell the nurse whether the resident needed to be sent out to the hospital, administered any other medications or monitored. RN #1 said she would also need to assess the resident's vital signs, notify the unit manager and the DON about the medication error and monitor the resident for any changes in condition or abnormalities.Licensed practical nurse (LPN) #1 was interviewed on 10/8/25 at 12:50 p.m. LPN #1 said she worked for an outside agency contracted by the facility, but had worked at the facility several times in the past. LPN #1 said for medication administration, she gathered medications according to what was marked as due in the resident's MAR. LPN #1 said when administering medications, she checked the resident's photo and asked the resident to tell her their name in order to verify their identity, or had another nursing staff member identify the resident if they were unable to do so themselves, in order to avoid a medication error. LPN #1 said it was important to ensure the right resident was taking the right medications to avoid medication errors. LPN #1 said if a medication error did occur, she would immediately notify the DON, the unit nurse and the resident's physician, monitor the resident's vital signs and monitor the resident for any changes.The DON was interviewed on 10/8/25 at 2:48 p.m. The DON said when nurses did their medication administrations, the DON's expectation would be that the nurse would have the resident's MAR in front of them on their computer, and would look to see what medications were due. The DON said the nurses would then verify to ensure the resident was receiving the right medication for the right resident, the right dose, the right time and the right route. The DON said nurses should verify they were administering medications to the right resident by asking the resident their name or date of birth and by verifying the resident's photo matched the resident in front of them. The DON said the nurses would then tell the resident what medications they were administering to them, watch the resident take the medications and ensure the medications were (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065379	A. Building B. Wing	12/08/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	administered, then mark the medications as administered in the resident's MAR. The DON said as soon as a nurse was aware of a medication error, they should assess the resident right away and notify the resident's physician. She said once the resident was safe and stable, the nurse should notify the facility managers and the resident's representatives. For Resident #19, the DON said the facility was notified about the medication error by the hospital after the resident was sent out for her change in condition. The DON said the hospital had called the nurse on duty that evening and informed her Resident #19 told the hospital staff she thought she had been administered the wrong medications, as her medication cup said the name of a different resident. The DON said the nurse who had administered medications that day should not have pre-poured medications. The DON called the nurse who had been working that day and interviewed her on the course of events that day. The DON said the nurse said she had administered the correct medications to the correct residents, and it was her understanding Resident #19 had a change of condition.The DON said the facility began investigating the potential medication error the following morning (8/22/25) based on what the hospital reported, and began to get statements from Resident #19, her roommate, and pertinent staff. The DON said when they interviewed Resident #19's roommate she was concerned, as Resident #19 had told her the medication cup she was given had the wrong name on it, and the resident encouraged Resident #19 to talk with her nurse. Based on their investigation, the facility staff assumed Resident #19 received Resident #26's medications.The DON said Resident #19 had not had any adverse effects from the medication error. The DON said the hospital provided Resident #19 with monitoring and intravenous fluids before discharging her back to the facility the following day.The DON said the facility immediately began educating the nursing staff on medication administration, and the agency nurse who initiated the medication error was not permitted to return to the facility. The DON said the resident's photos in their EMRs were updated as a result of the medication error and would be updated at least annually going forward.The DON said it was important for residents to receive their medications as ordered to avoid the residents having any adverse medical reactions to medications given in error, and so they were treated therapeutically for whatever diagnoses the medications were ordered for by their physicians.The NHA and the ADON were interviewed together on 10/8/25 at 4:07 p.m. The NHA said whenever she signed a new contract with an outside nursing agency, she ensured the agency's requirements met or exceeded the facility's requirements. The NHA said for Resident #19's medication error, the facility assumed the resident had been administered Resident #26's medications, but they were not able to verify this information. She said the facility immediately reported the nurse to her outside nursing agency, and the nurse was suspended from the agency services. The NHA said she initiated a performance improvement plan at that time for medication administration.The ADON said she initiated medication administration observations and medication cart audits after the 8/21/25 medication error. The ADON said she also began updating all of the resident's pictures in their EMRs. VI. Resident #18A. Resident statusResident #18, age greater than 65, was admitted on [DATE]. According to the October 2025 CPO, diagnoses included malnutrition, hypertensive heart disease and personal history of traumatic brain injury.The 8/8/25 MDS assessment indicated the resident was cognitively intact with a BIMS score of 13 out of 15. The assessment documented the resident needed substantial assistance from staff for most ADLs.B. Resident representative interviewResident #18's representative was interviewed on 10/8/25 at 9:01 a.m. The resident's representative said Resident #18 had an incident in which he and his roommate had agreed to switch sides of their room, and Resident #18 ended up getting his roommate's (Resident #16) medications. The resident's representative said Resident #18 slept most of the day on 9/21/25 but was fine the following day. The resident's representative said she had met with the DON to find out (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065379	A. Building B. Wing	12/08/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	what they were going to put into place to keep the incident from happening again. The resident's representative said the DON had interviewed every staff member and resident pertinent to the investigation and had everything in place before she met with the representative. C. Record reviewThe October 2025 CPO revealed Resident #18 had physician's orders for the following daily scheduled medications: furosemide (used to treat edema) 20 mg, lactase (used to treat loose stools) 3000 units, vitamin D supplement 1000 units, Senna Plus (used to treat constipation) 50 mg, acetaminophen 1000 mg and morphine sulfate (an opioid pain medication) 0.25 milliliters.A progress note, dated 9/21/25 at 2:06 p.m., revealed a facility nurse called Resident #18's hospice nurse to alert them of a change in condition for the resident. Resident #18 had been asleep most of the morning of 9/21/25 and was unable to fully arouse. Resident #18 was able to take his medications that morning (on 9/21/25) and that afternoon but needed a lot of cueing from the nurse. Resident #18 at one point put his hand over his mouth and said his medications tasted horrible when they were crushed and put in his pudding, but the resident did swallow his medications successfully. Resident #18 was assisted into his bed after lunch for a nap. Resident #18's vital signs were assessed at that time, at which point his blood pressure measured 143/105 mmHg and his pulse was 54 beats per minute (BPM) using a vital signs machine. The nurse assessed Resident #18's blood pressure manually and found his blood pressure was 130/65 mmHg and his pulse was approximately 60 BPM. A certified nurse aide (CNA) said Resident #18's behavior was normal for him as he was usually out of bed and self-propelling around the unit in his wheelchair. Resident #18 appeared to be very lethargic. During an assessment, the nurse asked Resident #18 to squeeze her hand and the resident did not follow the verbal command. Resident #18 was not responsive when the nurse asked him if he was in any pain. The hospice nurse said a nurse from the hospice agency would go out to the facility to evaluate the resident.A progress note, dated 9/21/25 at 3:20 p.m., revealed during shift change on 9/21/25 it was reported to the incoming nurse that Resident #18 was not listed to be in the correct bed the night prior in the EMR. The other nurse told the nurse documenting the progress note that the issue of Resident #18 being in the wrong bed almost caused her to make a medication error, but she caught it in time. The nurse documenting the note said she knew the residents on the unit, including Resident #18, therefore she knew the residents received their correct medications for the morning and afternoon medication administration times on 9/21/25.As the nurse was in Resident #18's room following up on his suspected change in condition, the resident's roommate (Resident #16) approached the nurse and told her he thought she should know Resident #18 may have gotten Resident #16's medications the night prior on accident. Resident #16 told the nurse that the nurse on duty the night prior had attempted to give Resident #16 morphine, to which the resident replied he did not take that medication. The nurse repeatedly asked Resident #16 if he was refusing to take the medication she was trying to give him, and he repeatedly answered yes, as he did not take those medications. Resident #16 told the nurse Resident #18 took the medications which were administered to him, and Resident #16 overheard Resident #18 say there were a lot of medications in his cup.The nurse alerted the DON immediately and contacted Resident #18's physician and family. The nurse updated the EMR to reflect the new bed arrangement for both Resident #18 and Resident #16.A progress note, dated 9/21/25 at 4:13 p.m., revealed Resident #18 was resting in bed. Resident #18 remained lethargic but his vital signs were stable, with the exception of his body temperature measuring 96.4 degrees Fahrenheit. Resident #18's blood pressure was assessed to be 137/78 mmHg, and his pulse was 70 BPM. Resident #18 responded to verbal stimuli and touch but promptly went back to sleep. The hospice nurse arrived at the facility and assessed Resident #18.A progress note, dated 9/21/25 at 6:03 p.m., revealed Resident #18 started to arouse. Resident #18 was adjusting his blankets when a (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065379	A. Building B. Wing	12/08/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	nurse entered his room to check on him. Resident #18 said he was tired and was not hungry for his dinner, and said he was going to go back to sleep. Resident #18's hospice nurse submitted a new physician's order for the resident (see hospice note below).Hospice notes, dated 9/21/25, revealed a physician's order from Resident #18's hospice provider to hold all medications for 24 hours or until Resident #18 was awake and alert, resulting from a suspected medication error on 9/20/25. The facility was to assess Resident #18's vital signs every two hours through 12:00 a.m. on 9/22/25. A progress note, dated 9/22/25 at 1:58 p.m., revealed Resident #18 was more energetic and was out of bed as of that morning (9/22/25). Resident #18 ate his lunch and was up in his wheelchair.A progress note, dated 9/23/25 at 9:58 a.m., revealed education on the medication error was provided to facility staff, and medication observations and an investigation into the error were completed and reviewed by the interdisciplinary (IDT) team.The facility investigation, dated 9/22/25, was provided by the NHA on 10/8/25 at 10:26 a.m. and revealed the following:A medication error report, dated 9/22/25, revealed Resident #18 was given another resident's medications. A description of the error documented there was a potential medication error due to Resident #18 switching which side of the room he used with his roommate without having it changed in the EMR. Resident #18's hospice provider was notified of the incident on 9/21/25 at 3:20 p.m., and provided physician's orders to hold all further medications and to begin checking the resident's vital signs every two hours. Resident #18's representative was notified of the error on 9/21/25 at 3:20 p.m. The corrective action the facility took included relieving the nurse who caused the medication error of her duties and educating the entire nursing staff.On 9/22/25 at 8:30 a.m. the DON spoke with the nurse who was on duty the evening of 9/20/25 (RN #3). The DON explained to RN #3 that an investigation had been initiated involving a potential significant medication error that occurred on 9/20/25. The DON explained a resident had reported a nurse attempted to administer morphine to him when the resident was not ordered to have morphine. The resident then reported he believed his roommate had accidentally received his medications in error. RN #3 said she noticed Resident #18 and Resident #16 were in the wrong beds in their EMR. RN #3 said she verified the residents by their names before administering their medications. RN #3 said Resident #18 was administered morphine and his other medications as ordered, and Resident #16 had refused his medications because she was administering them too late in the evening. RN #3 said she did not note any change in condition of Resident #18 during her shift.A statement from a nursing staff member, dated 9/22/25, revealed Resident #16 called the staff member into his room around midnight on 9/20/25, as he thought RN #3 had tried to give Resident #18 his medications in error. The staff member said he got RN #3 to go back into Resident #16 and Resident #18's room, but she only briefly went into the room before leaving again.A statement from Resident #16, dated 9/22/25 at 11:30 a.m., revealed Resident #16 had already planned to refuse his medications that evening as he felt they were being administered too late. Resident #16 said he heard Resident #18 say he had a lot of pills to take in his medication cup and needed to sit up so he could take them. RN #3 then approached Resident #16 and asked him if he wanted to take his morphine. Resident #16 told RN #3 he did not take morphine, and RN #3 left the room abruptly afterward. Resident #16 called another staff member into his room and told him what occurred with RN #3 and asked him what to do, to which the staff member told Resident #16 he needed to contact one of the facility's management team. RN #3 entered the room shortly thereafter and asked Resident #16 if he needed to speak with her. Resident #16 said he asked RN #3 if she gave Resident #18 his medications, and the nurse said no and told him about some issue with her computer.D. Resident #16's interviewResident #16 was interviewed on 10/7/25 at 3:05 p.m. Resident #16 said there was an instance in which his roommate (Resident #18) received his (Resident #16) medications and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065379	A. Building B. Wing	12/08/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	became really sick. Resident #16 said a nurse gave Resident #18 his medications and the process sounded different than usual. Resident #16 said he heard Resident #18 say That is a lot of pills, which Resident #16 thought was odd because he (Resident #16) took a lot of medications but knew Resident #18 did not. Resident #16 said he heard Resident #18 having a hard time swallowing all of the medications that evening. Resident #16 said when the nurse finished administering Resident #18's medications, she approached him (Resident #16) and tried to give him his medications. Resident #16 said when he refused his medications, the nurse asked him if he was sure he did not want to take his morphine. Resident #16 said he told the nurse he did not take morphine. Resident #16 said Resident #18 slept for a few days after the medication error incident but had been fine since then.Resident #16 said he and Resident #18 had agreed to switch their sides of the room that day (9/20/25). Resident #16 said he often got too hot on his side of the room and Resident #18 was too cold on his side of the room, so they switched sides so Resident #16 could be closer to the air conditioning unit. Resident #16 said he was not sure how the nurse was able to mix up himself and Resident #18, as the residents were of different ethnicities and age groups. Resident #16 said the nurse should have at least looked at the photos of the residents in the computer before giving them their medications.E. Staff interviewsThe DON was interviewed on 10/8/25 at 2:48 p.m. The DON said the ADON conducted the investigation for Resident #18's medication error. The DON said she was notified of a potential medication error, as Resident #16 was concerned and thought Resident #18 may have received his (Resident #16) medications prior to Resident #18 having a change in condition. The DON said Resident #18 was usually up and active, but had not wanted to get out of bed the morning of 9/21/25. Resident #18 was being monitored by hospice services at the time. The DON said she tried to reach