STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065113	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medallion Post Acute Rehabilitation	1719 E Bijou St Colorado Springs, CO 80909

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 - Immediate jeopardy to resident health or safety

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 47151

Based on record review and interviews, the facility failed to ensure one (#1) of three residents at risk for elopement out of seven sample residents received adequate supervision and were kept free from elopement.

Specifically, the facility failed to provide Resident #1 the supervision necessary to prevent elopement. The facility failures created a situation with serious harm and a situation of likelihood of serious harm to residents' health and safety if not immediately corrected.

Resident #1, diagnosed with metabolic encephalopathy (improper brain function due to underlying medical condition), unspecified psychosis (mental condition caused by loss of contact with reality), dementia and anxiety, eloped from the facility on 2/1/25 at an unknown time.

Facility staff were unaware Resident #1 was missing until after 6:00 a.m. on 2/2/25 when certified nurse aide (CNA) #2 began answering call lights at the start of her shift. At approximately 6:20 a.m. on 2/2/25, CNA #2 noticed Resident #1's dinner tray, untouched, in the resident's room. Resident #1's roommate reported to CNA #2 she had not heard Resident #1 in the room since approximately 5:30 p.m. on 2/1/25, the previous day. CNA #2 reported this to a nurse on duty and the assistant director of nursing (ADON) was notified at approximately 6:30 a.m. A full facility check was conducted, the staff checked the surrounding neighborhood and the resident was unable to be located. At 8:10 a.m. the admissions coordinator (AC) informed the interdisciplinary team (IDT) that Resident #1 had been located at a local hospital.

The facility began investigating the incident immediately after Resident #1 was discovered in care of the local hospital and determined Resident #1 eloped from the facility after CNA #1 and licensed practical nurse (LPN) #1 failed to monitor Resident #1 every two hours per facility protocol and due to Resident #1's refusal to wear a wanderguard.

Findings include:

Observations, interviews and record review confirmed the facility corrected the deficient practice prior to the onsite investigation on 2/12/25 to 2/13/25, resulting in the deficiency being cited as past noncompliance with a correction date of 2/4/25.

I. Situation of serious harm

(continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility failed to ensure the facility staff performed a check of Resident #1 every two hours throughout the evening on 2/1/25 resulting in the facility being unaware of Resident #1's whereabouts for approximately 12 to 15 hours. Resident #1 eloped from the facility on 2/1/25 and was found by the local police approximately 0. 3 miles from the facility. She was taken to a local hospital for evaluation where she was admitted at 8:36 p.m. and treated for a urinary tract infection (UTI). II. Facility plan of correction The corrective action plan the facility implemented in response to Resident #1's elopement incident on 2/2/25 was provided by the clinical resource (CR) on 2/12/25 at 2:30 p.m. A. Immediate action One-on-one education was provided to the staff who worked on the 2/1/25 overnight/evening shift and CNA #1 and LPN #1 were placed on suspension pending the investigation of Resident #1's elopement. A facility wide resident count was conducted and all other residents were accounted for. An assessment was conducted of all exterior doors and doors and door alarms were all functioning properly. The incident investigation began immediately and was conducted by the director of nursing (DON) and the nursing home administrator (NHA). B. Identification of others affected The facility determined the deficient practice had the potential to affect all the residents in the facility. C. Systemic changes The DON educated all of the staff on the importance of staff expectations with rounding, high risk for elopement residents (if a resident had not been seen in a few hours), reviewing the resident sign out book, any resident that required one-to-one staff to resident monitors, frequent or 15-minute checks and the post test for elopement. Residents in the facility were interviewed and educated on the use of the resident sign out log. D. Monitoring The facility would evaluate the effectiveness of the plan in quality assurance and program improvement (QAPI) committee meetings for three months and implement additional interventions as needed to ensure sustained compliance. Audits, along with resident records reviewed and analysed for trends, would be reported monthly to the QAPI committee. III. Facility policy and procedure The Elopement/Unsafe Wandering policy, undated, was provided by the CR on 2/12/25 at 2:30 p.m. The policy read in pertinent part, This facility is committed to promoting resident autonomy by providing an environment that remains as free of accident hazards as possible. Each resident is assisted in attending or maintaining their highest practicable level of function through providing the resident adequate supervision and diversional programs to prevent unsafe wandering while maintaining the least restrictive environment for those at risk for elopement. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Wandering is defined as random or repetitive locomotion and can either be goal directed or non-goal directed and aimless. Elopement is when a resident leaves the facility premises or a safe area without authorization and/or any necessary supervision to do so. Residents with capabilities of ambulation and/or mobility in a wheelchair will have an unsafe wandering evaluation completed to determine risks for elopement and unsage wandering on admission and with observed behaviors of wandering or attempting to elope. Residents with high risk factors identified on an elopement/wandering evaluation are considered at risk and will have an individualized care plan developed that includes measurable objectives and time frames. The care plan interventions will consider the particular elements of the evaluation that put the resident at risk and the observations of wandering behavior. These interventions will address the individualized level of supervision needed to prevent elopement and unsafe wandering. Staff shall promptly report any resident who is trying to leave the premises, or is suspected of being missing, to the charge nurse or supervisor to evaluate the need for further interventions. If a resident is missing, it is a facility-wide emergency. The missing resident procedures will be initiated. Determine if the resident is out on an authorized leave or pass. If the resident was not authorized to leave, institute a search of the premises. If the resident is unaccounted for after a thorough search of the building and grounds, immediately notify the IDT team, the resident's legal representative or emergency contact, physician and law enforcement. A review of the elopement incident by the IDT will include an investigation to determine safety of the environment and probable cause factors leading to the elopement. A summary of the investigation and recommendations will be documented in the resident's medical record. IV. Resident #1 A. Resident status Resident #1, age greater than 65, was admitted on [DATE] and discharged to the hospital on 2/1/25. According to the February 2025 computerized physician orders (CPO), diagnoses included metabolic encephalopathy, frostbite, unspecified psychosis, convulsions, dementia and anxiety. The 12/22/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview for mental status score (BIMS) of eight out of 15. The 2/1/25 discharge MDS assessment documented Resident #1 required set-up assistance for meals, dressing, personal hygiene and dressing. She was independent with all other activities of daily living (ADL). The assessment documented the resident wandered one to three days during the assessment period, experienced delusions and rejected care. B. Record review 1. Care plans (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #1's comprehensive care plan, initiated 4/19/24 and revised 6/24/24, documented Resident #1 was an elopement risk and exhibited wandering behaviors related to her impaired safety awareness and had two previous elopements. Pertinent interventions, initiated 6/18/24 and resolved 6/24/24, included one-to-one staff supervision and to document wandering behavior and attempted diversional interventions. Resident #1's dementia care plan, initiated 6/24/24 documented the resident was at risk for acute confusional episodes and had a history of elopements related to dementia with exit seeking behaviors. Pertinent interventions, initiated 6/24/24, included to document wandering behavior and attempted diversional interventions, completing one-to-one staff supervision or 15-minute checks as needed, reminding the resident where her room was and that it was divided by the curtain, identifying the resident's pattern of wandering - was it purposeful, aimless or escapist and intervening as appropriate and redirecting the resident as needed. Resident #1's care plan for ADLs, initiated 12/28/22, revealed she had a self-care performance deficit related to impaired mobility and cognition due to dementia. She refused medications, medical testing and labs, vital signs, assessments and showers. Pertinent interventions, initiated 12/30/22, included to converse with the resident while providing care, explaining all procedure and tasks before starting and providing the resident required set-up assistance to eat. 2. Elopement/wandering evaluation Resident #1's 12/20/24 elopement/wandering evaluation documented she had a predisposing condition of mental illness, was disoriented and ambulated independently and/or with supervision. The evaluation further documented Resident #1 did not have a history of elopement and the resident had no history or current behavior of wandering within the look back period of the previous six months. -However, the resident's February 2025 CPO documented Resident #1 had a diagnosis of dementia, which was not indicated on the elopement/wandering evaluation (see interviews below). The resident's electronic medical record (EMR) documented wandering behaviors (in the last six months prior to the elopement/wandering evaluation) on 6/25/24 and 7/21/24, in which Resident #1 attempted to leave the facility and the wanderguard alarm was activated. 3. Treatment records and progress notes A review of Resident #1's February 2025 treatment administration record (TAR) revealed on the 2/1/25 to 2/2/25 overnight shifts from 6:00 p.m. to 6:00 a.m., LPN #1 documented that Resident #1 had zero exit seeking attempts. The TAR further documented Resident #1 was provided with non-pharmacological interventions for pain that included dim light, a quiet environment, relaxation and distraction. A review of Resident #1's EMR revealed the following documentation completed by CNA #1: -Resident #1's fall prevention intervention of a low bed in place was documented at 9:26 p.m. on 2/1/25 and 1:35 a.m. on 2/2/25; -Resident #1's snack was documented as accepted at 9:26 p.m. on 2/1/25; and, (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Resident #1 was documented as being turned and repositioned at 9:27 p.m. on 2/1/25 and at 1:35 a.m. on 2/2/25. -However, Resident #1 was admitted to the hospital on 2/1/25 at 8:36 p.m. after being found downtown by police. -The facility failed to recognize Resident #1 was not in the building until after 6:00 a.m. the following morning (2/2/25). A 2/3/25 IDT note, written at 11:39 a.m. and related to Resident #1's elopement, documented it was noticed by the facility staff on 2/2/25 at approximately 6:10 a.m. that Resident #1 was not in the facility and the facility's elopement protocol was initiated. Resident #1 was located at a local hospital where she was admitted on [DATE] at 8:36 p.m. after being found by police downtown. It was discovered that the assigned LPN (LPN #1) and CNA (CNA #1) did not follow facility policy and procedure during their shift and were placed on suspension pending investigation. The resident had been accepted to a secure unit at another facility after her hospital discharge. C. Review of Resident #1's elopement incident on 2/1/25 On 2/12/25 at 2:30 p.m. the CR provided the investigation of Resident #1's elopement on 2/1/25. The investigation revealed the following: On 2/1/25 staff reported seeing Resident #1 in the hallways from 2:00 p.m. to 3:00 p.m. On 2/1/25 at 5:00 p.m. CNA #1 said Resident #1 was not in her room and to mark her down for the regular meal. On 2/1/25 at 6:00 p.m. Resident #1's dinner tray was delivered to her room. On 2/1/25 at 9:26 p.m. CNA #1 documented Resident #1 ate 100% (percent) of her meal. On 2/1/25 at 11:41 p.m. LPN #1 documented she had completed a pain evaluation for Resident #1 and that the resident had no exit seeking attempts for the 6:00 p.m. to 6:00 a.m. shift. On 2/2/25 at 6:00 a.m. CNA #2 arrived to the facility, took a report from the night shift CNA #1, and immediately went to the hall and answered the call lights. On 2/2/25 at 6:15 a.m. a bath aide told CNA #2 that Resident #1 was not in her room. Resident #1's roommate said she had not heard her roommate in the room since 5:30 p.m. the night before. On 2/2/25 at 6:20 a.m. CNA #2 reported to a nurse and LPN #1 she could not find Resident #1. LPN #1 told CNA #2 she saw Resident #1 walking down the hallway at 3:00 a.m. -However Resident #1 had already been admitted to the hospital on 2/1/25 at 8:36 p.m. On 2/2/25 at 6:30 a.m. CNA #2 called the ADON to report she was unable to find Resident #1. The staff were instructed to conduct a full facility check for the resident, including bathrooms, back hallways, the garden and surrounding outside areas. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/2/25 at 7:36 a.m. the IDT was alerted the resident was unable to be located. The DON arrived at the facility immediately after and conducted a second search of the facility and surrounding outside areas. At 8:10 a.m. the AC informed the IDT that Resident #1 had been located at a local hospital. At 8:20 a.m. the DON arrived back at the facility after looking for the resident in the surrounding area and a house wide resident count was conducted and all other residents were accounted for. An assessment was conducted of all exterior doors and door alarms and all were all functioning properly. An internal investigation was initiated by the DON and the NHA. LPN #1 was interviewed on 2/2/25 by the DON. LPN #1 stated she heard Resident #1 in her room around 3:00 a.m. when she was taking care of the resident's roommate. LPN #1 said she had not laid eyes on Resident #1 during her shift. LPN #1 explained that her documentation on Resident #1 on the overnight shift was just documentation on the resident's' usual' to explain Resident #1's pain evaluation and number of times the resident attempted to exit the facility. CNA #1 was interviewed on 2/2/25 by the DON. CNA #1 said she documented Resident #1's meal was 100% of the meal intake because Resident #1 did not like to be bothered when she was in her room. LPN #1 and CNA #1 were asked by the DON during the investigation to provide written statements for the events involving Resident #1 on 2/1/25 and 2/2/25, but they did not. V. Staff interviews The CR was interviewed on 2/12/25 at 2:35 p.m. The CR said the facility placed a wanderguard bracelet on Resident #1's wrist in June 2024 and she removed it multiple times until August 2024 and she refused multiple times to have the bracelet placed back on her wrist. The CR said Resident #1 was supposed to be on two-hour checks at the time of her elopement and staff were to check on her every two hours because she was refusing to have the wanderguard on. The CR said the facility thought it had to be around suppertime that the resident left the building through the front door because the front door closed at 6:00 p.m. Dietary aide (DA) #1 and DA #2 were interviewed together on 2/13/25 at 9:55 a.m. DA #1 said residents could exit the facility through the front door or through one of the dining rooms' side doors. DA #1 said the side doors of the dining room went to a lobby and were alarmed. DA #1 said if a resident had a wanderguard on and tried to exit through the side doors, the wanderguard alarm on the wall would sound. DA #1 said if the alarm sounded, there was a code that could be entered to turn the alarm off. DA #1 said residents could also use the dining room side door to go visit a friend in assisted living or get a coffee in the other dining room of the building. DA #1 said she was not at the facility when Resident #1 eloped but she knew of Resident #1. DA #1 said it seemed as though Resident #1 had days she wanted to leave the buildings more than others. DA #1 said she knew who the at-risk residents were in the building and monitored them in the dining room even if they were not attempting to leave through the side door. DA #2 said the dietary staff knew which residents should be redirected away from the dining room side door and the staff should check the elopement wanderguard book every day. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The AC was interviewed on 2/13/25 at 10:20 a.m. The AC said was educated on the facility elopement policy after Resident #1's elopement from the facility. The AC said she came to the facility on the morning of 2/2/25 and called local hospitals. The AC said she discovered Resident #1 was in a local hospital during the first phone call she made. The AC said when elopements happened, the facility staff all had specific assignments. She said some staff contacted the hospital and other staff might contact the jails or homeless shelters. The AC said when she called the hospital, she provided specific resident information and the hospital was able to tell her Resident #1 was there. The AC said the facility staff might have to visit the homeless shelters in person because the homeless shelters did not typically provide information on who was there. The AC said if a resident had previously eloped, the facility would try to find that resident at their known or favorite place first. The social services assistant (SSA) was interviewed on 2/13/25 at 11:15 a.m. The SSA she was educated about Resident #1's elopement. The SSA said she had worked at the facility for a very long time and worked various positions in the facility that included the front desk of the assisted living (AL) facility connected to the nursing facility. The SSA said she knew which residents were at risk for elopement and those residents lived on the nursing side of the facility. The SSA said residents at risk for elopement were noted upon admission. She said she noted residents with a dementia diagnosis, even if that resident was not a high elopement risk and also looked out for those residents. The SSA said if a resident consented, the facility took a picture of the resident and included the resident's picture with their information in the elopement binder. The SSA said when she took her break she locked the front doors of the building so people could not enter from the outside, but residents were still able to exit. She said she locked the entrance doors with a key and on the inside of the door she hung a stop sign. The SSA said the stop sign was effective in deterring residents from exiting through the double doors. The SSA said if a resident who was an elopement risk started to or did exit the building through the AL side of the building, or if she was notified of a resident elopement, she immediately called to the nursing side of the facility. The SSA said she would try to reach the DON or other nursing supervisor to inform them of a potential elopement. The SSA said she would also inform the facility plant manager and then attempt to redirect the resident back inside the building. The SSA said she took her cell phone with her to update other staff by phone if she was successful or not in redirecting the resident. The SSA said the facility employed overnight staff that did laundry and while waiting for the laundry to finish, the overnight staff did security rounds outside the facility and checked entrances and doorways. LPN #2 was interviewed on 2/13/25 at 12:10 p.m. LPN #2 said if he was informed of a resident elopement, he would immediately lock his medication cart and start looking for the resident. LPN #2 said if he had to report a resident missing, it depended on the resident what he would report. LPN #2 said some residents were more independent and could sign themselves out of the facility. LPN #2 said if that was the case, he would check the sign out log to see where the resident signed out to go, and then inform the DON or the ADON if he thought the resident had been gone too long. (continued on next page)

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