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	04/22/2025

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 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47350 Based on record review and interviews, the facility failed to provide treatment and care in accordance with professional standards for one (#2) of three residents out of nine sample residents. Resident #2, who had a history of falling and previous fractures that included a burst fracture of the thoracic vertebra (bone in the upper spine caused by trauma), was admitted to the facility on [DATE]. On 2/11/25 at 6:45 a.m. Resident #2, who ambulated independently with her walker, slipped and fell while walking to the bathroom. After the fall, Resident #2 was heard yelling. A licensed practical nurse (LPN) went to check on the resident and found her lying on her left side, complaining of 8 out of 10 pain, on a 1 to 10 pain scale, to her left shoulder and left hip. According to the LPN's documentation of the fall, Resident #2 refused to allow nursing staff to remove her clothing for a skin evaluation and she requested to be transported to the hospital at that time. The LPN notified the director of nursing (DON), who was the registered nurse (RN) on-call, to notify her of his findings, which included Resident #2's complaints of 8 out 10 pain to her left shoulder and left hip. Resident #2 was assisted into a wheelchair by the LPN and a certified nurse aide (CNA). The 2/11/25 at 6:50 a.m. nursing progress note, written by the DON, documented a RN assessment conducted by the DON, based on the findings reported from the LPN on-site at the time of the resident's fall. It indicated Resident #2 had slipped and fallen while ambulating to the bathroom. It documented Resident #2 was able to move all extremities without injury or noted deformity. It documented Resident #2 was to be transported to the hospital after Resident #2 and Resident #2's representative insisted the resident be evaluated at the hospital. -However, there was no RN in the facility at the time of the fall to conduct a hands-on physical assessment of the resident. Resident #2 was moved off the floor and into a wheelchair, despite her complaints of significant pain, refusal to remove her clothes for a skin evaluation and her request to be sent to the hospital. (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 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Resident #2 was transported to the hospital on 2/11/25 at 7:48 a.m. after Resident #2's representative was notified of the resident's fall and insisted on Resident #2 being evaluated at the hospital (63 minutes after Resident #2 initially requested to go to the hospital). At the hospital, the resident was diagnosed with a dislocated and fractured left shoulder and a fractured left hip that required surgical intervention, The facility's failure to accurately assess and evaluate Resident #2 after she experienced a fall and complained of acute pain of 8 out of 10 to her left shoulder and left hip, and the facility's failure to honor the resident's request to be sent to the hospital immediately after the fall resulted in Resident #2 not being transported to the hospital in a timely manner for evaluation and treatment of her acute fractures. Findings include: I. Professional reference According to The Cleveland Clinic (5/11/23) Dislocated Shoulder, retrieved on 4/24/25 from https://my.clevelandclinic.org/health/diseases/17746-dislocated-shoulder, The most common symptoms of a dislocated shoulder include extreme pain, weakness, inability to move arm, shoulder being visibly out of place, swelling, bruising and muscle spasms. Any force that is strong enough to push your shoulder joint out of place can cause a dislocation. The most common causes include falls, care accidents and sports injuries. Go to the emergency room right away if you think your shoulder might be dislocated. According to John Hopkins Medicine (2025) Hip Fracture, retrieved on 4/24/25 from https://www.hopkinsmedicine.org/health/conditions-and-diseases/hip-fracture#:~:text=What%20is%20a%20hip%20fracture,of%20patients%20experience%20spontaneous%20fractures, A hip fracture is a partial or complete break of the femur (thigh bone), where it meets your pelvic bone. It is a serious injury that requires immediate medical attention. II. Facility policy and procedure The Fall Management System policy and procedure, revised November 2022, was provided by the director of nursing (DON) on 4/22/25 at 3:50 p.m. It read in pertinent part, When a resident sustains a fall, a physical assessment will be completed by a licensed nurse, with results documented in the medical record. The Monitoring for Significant Change in Condition policy and procedure, revised May 2007, was provided by the DON on 4/22/25 at 3:50 p.m. It read in pertinent part, If, at any time, it is recognized by any one of the team members that the care needs of the resident have changed, the nurse supervisor should be made aware of and he/she will monitor. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Change in ability to ambulate or propel wheelchair. Change in ability to transfer or position self. There will be certain circumstances where immediate attention will be warranted and nursing will be responsible for notifying the appropriate department for evaluation. II. Resident #2 A. Resident status Resident #2, age 86, was admitted on [DATE] and discharged to the hospital on 2/11/25. According to the February 2025 computerized physician orders (CPO), diagnoses included hypertension, protein/calorie malnutrition, opioid dependence and a fracture of thoracic vertebra (bone in the upper spine). The 1/13/25 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 required set up assistance with eating, personal hygiene and was independent with toileting, bed mobility and transfers. The assessment indicated Resident #2 used a walker to assist with ambulation. B. Resident representative interview Resident #2's representative was interviewed on 4/22/25 at 9:03 a.m. The representative said Resident #2 had a history of falls prior to being admitted to the facility. He said while she resided at the facility, she fell again (on 2/11/25). He said he was notified by the nurse on duty that his Resident #2 had fallen, approximately 30 minutes after the event. He said he asked the nurse if she was in pain and the nurse responded yes. He said he asked if the resident had requested to go to the hospital and the nurse had responded yes. The representative said he asked the nurse why emergency medical services (EMS) had not been called yet and he said he demanded the resident be sent to the hospital immediately. He said when he met Resident #2 at the hospital she was writhing and screaming out in pain. He said he was frustrated that she was not sent to the hospital when she had sustained multiple fractures, was in a lot of pain and when she had requested to go. C. Record review The acute/chronic pain care plan, initiated 10/10/24, indicated Resident #2 had acute and chronic pain management issues related to low back pain, history of falling and chronic pain. Interventions included administering analgesia (pain) medication per physician's orders, anticipating the resident's need for pain relief and responding immediately to any complaint of pain and identifying, recording and treating the resident's existing conditions, which may increase pain and or discomfort. -However, the care plan did not indicate the resident had chronic pain in her left shoulder or left hip. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The 2/11/25 at 6:50 a.m. nursing progress note documented a registered nurse (RN) assessment, conducted by the DON . Resident #2 was noted on the floor lying on her left side by the bathroom. Resident #2 said that she was walking to the bathroom and had slipped. Resident #2 was able to move all extremities with no signs of injury or deformity. It documented that neurological checks were started and at baseline for the resident. It documented that, based on the resident and resident representative's insistence, the resident would be sent to the emergency room for evaluation. -However, the DON's assessment was based upon the reported findings from the LPN who was on-site at the time of the fall (see interviews below). -Additionally, the nursing note was not created in the resident's electronic medical record (EMR) by the DON until 9:39 a.m. The 2/11/25 at 8:14 a.m. nursing progress note, written by the LPN on-site at the time of the resident's fall, documented that at 6:45 a.m. Resident #2 was heard yelling and was found lying on her left side on the floor in front of the bathroom. Resident #2 said she was ambulating with her walker to the bathroom and slipped. Resident #2 complained of pain at an 8 out of 10 to her left arm and left hip and requested to be sent to the hospital. Resident #2 refused to remove her clothing for a skin evaluation. Resident #2 was assisted into a wheelchair by the LPN and a CNA. The resident's representative was contacted and he requested for Resident #2 to be sent out to the hospital. The nurse practitioner (NP) and the DON were notified and Resident #2 was sent to the hospital. -However, the progress note failed to document whether or not the physician was notified that Resident #2 was reporting 8 out of 10 pain in her left shoulder and left hip and refusing to allow the nursing staff to remove her clothing for a skin evaluation, prior to moving the resident off of the floor. -Additionally, the progress note failed to document that physician's orders were obtained for Xrays, based on the resident's reports of 8 out of 10 pain in her left shoulder and left hip and her refusal to allow the nursing staff to remove her clothing for a skin evaluation, prior to Resident #2's representative insisting the resident be sent to the hospital. The 2/11/25 at 9:53 a.m. interdisciplinary team (IDT) fall committee progress note documented Resident #2 had an unwitnessed fall without injuries. It documented Resident #2 was lying on her left side on the floor in front of the bathroom. Resident #2 was sent to the emergency room for evaluation after Resident #2's, per the resident representative's insistence. It documented no injuries or deformities were noted by facility staff. -However, RN #1, who was not at the facility to physically assess Resident #2 at the time of the fall but received a shift hand-off report from the LPN that was on duty indicated the resident's shoulder looked odd (see interview below). -A comprehensive review of Resident #2's EMR failed to reveal documentation of a physician's order to obtain Xrays of the resident's left shoulder and/or left hip. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The 2/11/25 hospital progress note documented Resident #2 had a left shoulder dislocation with a proximal humerus fracture (a break in the long bone of the arm close to the shoulder) and a displaced left femur (thigh bone) fracture. It documented the resident's left shoulder was reduced (a procedure where the shoulder was placed back into position) in the emergency room by the orthopedic surgeon and the emergency room physician. The 2/12/25 hospital progress note documented Resident #2 underwent a left hip nailing (a surgical procedure to realign the bone and stabilize the fracture). III. Staff interviews RN #1 was interviewed on 4/22/25 at 1:50 p.m. RN #1 said Resident #2 had a walker which she used independently to walk around the facility. She said Resident #2 had a soft call light which she only used when she wanted her pain medications. She said the resident would not use the call light to ask for assistance prior to getting out of bed and walking with her walker. She said she took care of Resident #2 on the day she fell , but she said the resident had already fallen and been assisted into a wheelchair before she arrived in the facility for her shift. She said the previous nurse (LPN) had said that the physician had ordered Xrays and the facility was waiting for those Xrays to be obtained on her shoulder. She said Resident #2's left shoulder looked odd. She said the facility sent Resident #2 to the emergency room because the facility could not obtain the Xrays in a timely manner. -However, RN #1 did not document a progress note in Resident #2's EMR regarding her assessment that indicated the resident's shoulder looked odd (see record review above). -Additionally, progress notes indicated Resident #2 was sent to the hospital due to the resident representative's request that the resident be sent to the hospital, not because Xrays could not be obtained in a timely manner (see record review above). RN #1 was interviewed a second time on 4/22/25 at 1:55 p.m. RN #1 said she had reviewed her progress notes in Resident #2's EMR. She said Resident #2 had asked to go to the hospital and the LPN had called the physician but he had not received a return call. She said she was the one that had called the physician again and received an order for the resident to be sent to the emergency room because the Xrays could not be completed timely. She said that was the reason why there was a delay of over an hour between when the resident fell and when the resident was sent to the emergency room . RN #1 said the facility's process, unless a situation was immediately life-threatening, was not to call EMS first, but to call the physician to obtain a physician's order to transfer a resident to the hospital. She said the facility did this even if the resident had requested to go to the emergency room . -However, there was no documentation in Resident #2's EMR to indicate RN #1 or the LPN called the physician to obtain physician's orders for Xrays of the resident's left shoulder and left hip (see record review above). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The DON was interviewed on 4/22/25 at 2:45 p.m. The DON said the facility's process was to call the physician first to obtain a physician's order to transfer residents to the hospital to mitigate unnecessary hospitalization s, unless it met criteria for an immediate transfer. She said Resident #2 did not meet criteria for immediate transfer to the hospital. She said immediate criteria was any instance that was immediately life threatening. She said Resident #2 did not request to go to the hospital. She said Resident #2 was at baseline for her pain and she complained of pain normally at an 8 out of 10 pain scale. -However, the note documented by the LPN on 2/11/25 at 8:14 a.m. indicated Resident #2 requested to go to the hospital immediately after her fall (see record review above). -Additionally, Resident #2's acute/chronic pain care plan indicated the resident had chronic pain related to low back pain, not left shoulder or left hip pain (see record review above). The DON said Resident #2 normally, at baseline, did not have full range of motion in all of her extremities. She said the facility had contacted the physician and had obtained a physician's order for Xrays, since the facility could do these in the facility. She said Resident #2's representative was contacted and he insisted that Resident #2 be sent to the hospital. She said the facility sent Resident #2 to the hospital after Resident #2's representative insisted and the facility had obtained a physician's order from the NP to transport the resident to the hospital. The DON was interviewed a second time on 4/22/25 at 3:50 p.m. The DON said a RN was not in the facility when the fall occurred. She said she was the RN on-call and she had documented the RN assessment for Resident #2. She said the facility's process when an RN was not in the building was that the LPN would follow a post-fall check list and they would call the RN on-call. She said she was told by the LPN on-site that Resident #2 was not experiencing any pain or range of motion outside of her normal baseline. She said she did not come into the facility to personally assess the resident. She said Resident #2 was moved off the floor and into the wheelchair before the oncoming RN arrived at the facility. -However, the DON said in her previous interview on 4/22/25 at 2:45 p.m. that Resident #2 was at her baseline level of pain at the time of the fall (see interview above). -Additionally, the LPN's progress note documented Resident #2 was complaining of a pain level of 8 out of 10 to her left shoulder and left hip after the fall. -Additionally, the resident's representative indicated Resident #2 was in extreme pain when she arrived at the hospital (see resident representative's interview). IV. Facility follow-up On 4/23/25 at 1:53 p.m., after the survey exit, the DON provided the following timeline of Resident #2's fall via email: On 2/11/25 at 6:45 a.m. Resident #2 was heard yelling from the hallway and a nurse entered the room. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 2/11/25 at 6:50 a.m. the DON was called during the resident's evaluation as part of the required RN assessment. On 2/11/25, between 6:50 a.m to 7:30 a.m: An RN assessment was conducted. Resident #2 was noted on the floor laying on her left side by the bathroom. Resident #2 stated that she was walking to the bathroom and slipped. Resident #2 is able to move all extremities with no signs of injury or deformity. Neurological checks initiated and at baseline for this resident. Resident #2 was assisted up to her wheelchair by LPN and CNA. A call was made to the provider who gave orders for in-house Xrays. A call was placed to the resident's representative to report the incident and the representative requested Resident #2 be sent to the hospital. The provider called back and was informed of Resident #2's representative request to send the resident out to the hospital; an order was received from the provider. -However, a RN was not in the facility to conduct the assessment and the evaluation was provided by a LPN to the DON and Resident #2 was assisted up to the wheelchair by the LPN and a CNA before a RN was in the facility. The DON's 4/23/25 email additionally included the following EMS timeline from 2/11/25, which was provided to the facility by a dispatcher at (name of the EMS provider): On 2/11/25 at 7:30 a.m. call received by EMS from facility; On 2/11/25 at 7:44 a.m. EMS enroute to facility; On 2/11/25 at 7:48 a.m. EMS arrived to facility; On 2/11/25 at 8:07 a.m. EMS departed from the facility; On 2/11/25 at 8:16 a.m. EMS arrived at the hospital; and, On 2/11/25 at 8:19 a.m. Resident #2 was admitted to the hospital.