

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065278	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/04/2025
NAME OF PROVIDER OR SUPPLIER  Pelican Pointe Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  710 3rd St Windsor, CO 80550	

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)
<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50853</p> <p>Based on record review and interviews, the facility failed to ensure residents and their representatives were provided prompt efforts by the facility to resolve grievances for one (#3) of eight residents reviewed for grievances out of 14 sample residents.</p> <p>Specifically, the facility failed to document and follow-up on grievances reported by Resident #3 regarding a missing cell phone and eye glasses.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Grievances policy, dated December 2024, was provided by the nursing home administrator (NHA) on 2/4/25 at 2:07 p.m. It read in pertinent part,</p> <p>It is the policy of this facility to establish a grievance process that allows residents a way to execute their right to voice concerns or grievances to the facility without fear of discrimination or reprisal. The facility will make information on how to file a grievance available to the residents and make prompt efforts to resolve grievances that the residents may have.</p> <p>The facility's grievance official is responsible for overseeing the grievance process and for receiving and tracking grievances and leading necessary investigations by the facility.</p> <p>The grievance official evaluates and investigates the concern and takes immediate action to resolve the concern and prevent further potential violations.</p> <p>The grievance official will immediately report all alleged violations involving neglect, abuse, including injuries of unknown source, and misappropriation of resident property to the administrator and as required by state law.</p> <p>The grievance official responds to the individual expressing the concern within three working days of the initial concern to acknowledge receipt and describe steps taken towards resolution.</p> <p>I. Resident status</p> <p>(continued on next page)</p>

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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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #3, age 85, was admitted on [DATE]. According to the February 2025 computerized physician orders (CPO), diagnoses included chronic kidney disease, dementia, hypertension (high blood pressure) and depression.</p> <p>The 10/25/24 minimum data set (MDS) assessment revealed Resident #3 had severe cognitive impairment with a brief interview for mental status (BIMS) score of six out of 15. Resident #3 required partial to moderate assistance with personal hygiene and substantial to maximal assistance with transfers and walking short distances. He used a manual wheelchair for longer distances with partial assistance from staff.</p> <p>II. Resident and representative interview</p> <p>Resident #3 was interviewed on 2/3/25 at 10:15 a.m. Resident #3 said he wore his eye glasses when he could find them. He said they had been missing for a while.</p> <p>Resident #3's representative was interviewed on 2/3/25 at 9:46 a.m. The representative said Resident #3 had lost five cell phones and five pairs of eye glasses at the facility. She said she had tethered his last cell phone in his room so it could not be taken or lost. She said she did take the cell phone home a few months ago because Resident #3 did not understand how to use it anymore. She said the most recent pair of Resident #3's eye glasses were lost in December 2024 and replaced in early January 2025. She said the eye glasses went missing again two days after they were replaced and were still missing. She said she reported his missing items to the staff at the facility.</p> <p>III. Record review</p> <p>On 2/3/25 at 3:37 p.m. the social services director (SSD) provided the following grievance forms related to missing items for Resident #3:</p> <p>A grievance concern form, dated 1/31/24, was completed by the SSD and documented Resident #3 was missing a cellular phone, a television, a recliner, several items of clothing and a red blanket. It was noted on the form that the recliner was located and was missing again and the television was replaced by the facility.</p> <p>-There was no follow-up on the form for the other alleged missing items or what the facility was doing to safeguard the resident's items in the future.</p> <p>A grievance concern form, dated 12/5/24, was completed by the SSD and documented Resident #3's representative informed the facility that the resident was missing a pair of eye glasses that were delivered to the resident two weeks prior. The SSD documented a search of the resident's room was conducted on 12/6/24 and laundry/housekeeping staff were alerted to watch for the missing glasses. The glasses were confirmed to be lost, and on 12/12/24, the SSD requested the glasses be replaced. On 1/3/25 the grievance was resolved when new glasses were provided to Resident #3.</p> <p>-There was no documentation on the grievance form or in the progress notes indicating the resident representative was notified of the resolution or what measures were put in place to safeguard the resident's eye glasses.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-There was no grievance form documented for the eye glasses that were currently missing at the time of survey (2/3/25).</p> <p>IV. Staff interviews</p> <p>The SSD was interviewed on 2/3/25 at 2:47 p.m. The SSD said she was in charge of the grievances at the facility. The SSD said she was aware Resident #3's eye glasses were currently missing and she had called his insurance to get approval for new ones. The SSD said she did not complete a grievance because did not think the glasses were stolen. The SSD said the eye glasses that were currently missing were the second pair of glasses that had been replaced in the past few months for Resident #3. The SSD said Resident #3 was also missing two cell phones. She said one was replaced and then it went missing and had been missing for quite some time. The SSD said she should have completed a grievance form on the second missing pair of eye glasses and cell phones. She said she did not have any follow-up documentation on the missing eye glasses or cell phones.</p> <p>The SSD said the recliner from the 1/31/24 grievance form for Resident #3 was found in another resident's room and the television was replaced. She said there was no follow-up documented on the form, but the facility offered to replace the other items. She said she was not in charge of grievances in January 2024.</p> <p>The NHA was interviewed on 2/3/25 1:50 p.m. The NHA said he was aware Resident #3's eye glasses were missing again. He said he did not know if a new grievance form had been completed because the SSD was in charge of the grievances.</p> <p>The SSD was interviewed again on 2/4/25 at 10:50 a.m. The SSD said when a resident reported a missing item, a concern form should be completed and it should be reported to the NHA or designee. She said the facility reviewed grievance concerns during the morning meeting. The SSD said if an item was reported missing, the facility conducted a search right away for the missing item(s). The SSD said the facility would document the investigation and follow-up on the concern form or in a progress note.</p> <p>The SSD said the facility had tried different things to safeguard Resident #3's items but he had not been agreeable. She said the facility offered to lock up his eye glasses at night but he did not want the staff to take them. The SSD said Resident #3 did not want a chain or cord on his eye glasses. The SSD said the family decided not to provide another cell phone and staff were to take the resident a facility phone if he wanted to call his family. The SSD said the facility had educated staff to check the trash and the laundry for personal items.</p> <p>-However, the SSD was unable to locate documentation regarding the current missing items, investigation or follow-up.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The NHA provided an email on 2/5/25 at 3:39 p.m.,the day after the survey exit. In the email, the NHA said the facility held a care conference with Resident #3 and his representative on 2/5/25 at 1:30 p.m. The facility reviewed the concerns of lost glasses and the cell phone. The facility said the eye glasses would be replaced and when they were received, Resident #3 would be provided an eye glasses string holder so the eye glasses would be secure and not fall off his person. Staff would also monitor the eye glasses at night when the resident went to bed by putting the glasses in a case. The facility offered to replace the lost cell phone but the representative said Resident #3 was no longer physically able to use it so it was not necessary to replace it.</p> <p>-However, the facility did not address the above missing items for Resident #3 until after the missing items were identified during the survey (2/3/25 to 2/4/25).</p>