STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065278	A. Building B. Wing	05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pelican Pointe Health and Rehabilitation Center	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)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to provide treatment and care in accordance with professional standards for one (#5) of six residents out of nine sample residents. Specifically, the facility failed to respond to Resident #5's failure to void following the removal of the resident's catheter in a timely manner, which delayed the resident's transfer to the hospital.Resident #5 was admitted to the facility on [DATE]. Resident #5 was sent to the emergency department on 4/30/26 and returned the same day with an indwelling (tubing placed in the bladder) catheter for urinary retention and an order for an antibiotic. On 5/12/26 at approximately 1:30 p.m. the resident's indwelling catheter was removed per the physician's orders.On 5/12/26 at 7:45 p.m. Resident #5 was sitting in the dining room and told the nurse he was not feeling well. Resident #5 was escorted to his room and his vital signs were checked and within normal limits. The nurse documented the catheter had been removed earlier in the day and Resident #5 had not voided. The nurse attempted to use a bladder scan (machine to measure volume of urine in the bladder), however the bladder scan was not functioning.Resident #5's representative arrived at the facility and voiced multiple concerns regarding Resident #5 not voiding after the catheter was removed and the green exudate (fluid) that was noted on the meatus (tip) of the resident's penis. The nurse provided reassurance that efforts were ongoing regarding the bladder scanner and the resident's voiding issues. The resident's representative was informed the physician would be notified regarding the abnormal drainage and edematous (swollen) penis and lack of voiding since the resident's indwelling catheter had been removed. However, Resident #5's representative wanted Resident #5 sent to the emergency room and did not want to troubleshoot the issues at the facility. On 5/12/26 at 11:24 p.m. (over nine hours after the resident's catheter was removed) Resident #5 was sent to the hospital by emergency medical transport for further evaluation per the resident's representative's request.At the hospital, Resident #5 was found to have a distended bladder, suprapubic cramping, a strong urge to void, and green discharge from the urethral meatus. An indwelling catheter was immediately placed with a urine output of 1300 milliliters (ml). Resident #5 was diagnosed with urethritis (inflammation of the tube that carries urine out of the body), urethral discharge and retention of urine. The resident was discharged back to the facility on 5/13/26 with a physician's order for an antibiotic.Findings include: I. Resident #5A. Resident statusResident #5, age [AGE], was admitted on [DATE]. According to the May 2026 computerized physician orders (CPO), diagnoses included cerebral infraction, Parkinson's disease and Alzheimer's disease.The 3/30/26 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired with a brief interview for mental status (BIMS) score of three out of 15. The MDS assessment revealed the resident was dependent on staff for dressing, toilet hygiene, and personal hygiene. He was dependent on staff for transfers on and off the bed and on and off the toilet.The MDS assessment revealed the resident was incontinent of urine and did not have a catheter at the time of the assessment. B. Resident #5's representative interviewResident #5's representative was interviewed on 5/19/26 at 2:40 p.m. The representative said she was notified earlier in the day (on 5/12/26) , from their paid companion who sat with Resident #5 at the facility, of a discharge from Resident #5's penis. Resident #5's representative said she notified the director of nursing (DON) (continued on next page)

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	earlier in the day about the discharge and the DON told her that the discharge was normal. Resident #5's representative said she and her husband arrived at the facility at 7:30 p.m. She said Resident #5 was in his room and said he felt lousy and was holding his lower abdomen saying it hurt. Resident #5's representative said she asked the nurse to go to the room to look at Resident #5's penis because of the reported green discharge. Resident #5's representative said after they looked at the resident's penis, she asked for the resident to be sent to the hospital because his penis looked infected to her and her husband. She said the nurse told her the facility was able to manage his care. Resident #5's representative said she was told by the nurse that Resident #5's bladder had been scanned twice; however, when the nurse went to scan his bladder while they were there, the nurse said the bladder scan was not functioning. Resident #5's representative said she again requested that the resident be sent to the hospital because he had not voided or been checked in several hours and the resident was uncomfortable. She said she was told the resident did not need to go to the hospital because the facility could care for him in place. She said her husband then spoke with the DON and was told the laboratory (lab) work and a urine sample could be done at the facility. Resident #5's representative said the resident was acting like he needed to urinate and said he was cramping up. She said her husband took a urinal and with the help of a certified nurse aide (CNA), sat Resident #5 up at the edge of the bed but after five minutes, Resident #5 could not void. Resident #5's representative said she was provided with the option of the nursing staff performing a straight catheter (to drain the bladder) on Resident #5, but she said she did not want the facility to use a catheter at the facility due to the penis looking infected and the family wanted him at the hospital for the procedure. Resident #5's representative said she did not call the ambulance herself because she thought the facility had to make the call and have a physician's order for the transfer. She said a new nurse came into the resident's room after 11:00 p.m. (on 5/12/26) and agreed Resident #5 should go to the hospital and made the transfer arrangements. Resident #5's representative said during this time, from 7:30 p.m. until 11:00 p.m., she had asked for Resident #5 to go to the hospital but was told by the nurse and the DON that he could be treated at the facility, even after she declined to have a catheter done at the facility.C. Record reviewThe 5/12/26 nursing progress note, documented at 2:05 p.m., revealed Resident #5's indwelling catheter had been removed per physician's orders.Review of Resident #5's May 2026 CPO revealed a physician's order to discontinue the resident's catheter and perform post-void residuals every six hours for 24 hours. If greater than 400 ml of urine remained in the bladder after voiding or no voiding in 12 hours, staff were to notify the provider for new ordersThe 5/12/26 nursing progress note, documented at 7:45 p.m., revealed Resident #5 was sitting in the dining room and told the nurse he was not feeling well. Resident #5 was escorted to his room and his vital signs were checked and were within normal limits. The nurse documented the catheter had been removed earlier in the day and Resident #5 had not voided. The nurse attempted to use a bladder scan (machine to measure volume of urine in the bladder), however the bladder scan was not functioning.-There was no documentation to indicate the physician was notified regarding the resident's inability to void and the non-functional bladder scan machine.The 5/12/26 nursing progress note, documented at 9:00 p.m., revealed Resident #5's representative had arrived at the facility that evening and voiced multiple concerns regarding Resident #5 not voiding after the catheter was removed and the green exudate apparent on the meatus of the resident's penis. The nurse documented that she provided reassurance that efforts were ongoing regarding the bladder scanner, voiding issues, and all the rest and a call would be placed to the physician regarding the abnormal drainage and edematous (swollen) penis, and lack of voiding since the indwelling catheter had been removed. The 5/12/26 nursing progress note, documented at 10:40 p.m., revealed Resident #5's representative wanted Resident #5 sent to the emergency room and did not want to troubleshoot the issues at the facility. -However, the note was documented nine hours after the indwelling catheter had been removed and Resident #5 had not voided. Resident #5 had complained of not feeling well at 7:45 p.m., almost three hours prior.The 5/12/26 nursing progress note, documented at 11:24 p.m., (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	revealed Resident #5 was sent to the hospital by emergency medical transport per Resident #5's representative request.A review of Resident #5's hospital records, dated 5/12/26, revealed the resident was admitted to the hospital at 11:49 p.m. and discharged back to the facility on 5/13/26 at 7:44 a.m. with the diagnoses of urethritis, urethral discharge and retention of urine. During the hospital exam, Resident #5 was found to have a distended bladder, suprapubic cramping, a strong urge to void and green discharge from the urethral meatus. An indwelling catheter was immediately placed and immediate urine output was 1300 ml. Resident #5 was discharged back to the facility with a physician's order for an antibiotic.II. Staff interviewsThe medical director (MD), who was Resident #5's physician, was interviewed on 5/19/26 at 9:30 a.m. The MD said he would have expected a straight catheterization would have been performed if the resident did not void all day. He said his office was not notified until that night (5/12/26) of Resident #5 not being able to void or of the green exudate discharge from his penis. He said he was not aware the bladder scanner was not working on that day.The DON and the clinical resource nurse were interviewed together on 5/19/26 at 11:30 a.m. The DON said Resident #5 had his indwelling catheter removed (on 5/12/26) and the physician's order said to check post-void residuals every six hours. The DON said when the nurse was going to use the bladder scan for Resident #5, the resident's representative had come to the facility and started to ask questions. The DON said the nurse informed the representative the bladder scanner was not working and the DON was trying to obtain a bladder scanner from another facility. The DON said the family had been offered in-house interventions but the family made it clear they did not want another catheter inserted at the facility. The DON said the family did not trust the facility to manage the resident. The regional clinical nurse said Resident #5's indwelling catheter was discontinued at 2:05 p.m. on 5/12/26, per the nurse's progress note, however; the DON said the indwelling catheter was pulled at 1:30 p.m., not at 2:00 p.m. per the nurse's correction. The DON and the regional clinical nurse said it could take up to an hour to get a resident ready to go to the hospital unless emergency services were called. III. Facility follow-upNursing home administrator (NHA) #1 provided additional documentation on 5/20/26 at 4:26 p.m. (after the survey exit). The additional documentation included the following:A physician's visit progress note, dated 5/20/26 at 3:52 p.m., documented that the night Resident #5 was transferred to the hospital (5/12/26), despite needing a straight catheterization for urinary retention, this was refused by the Resident #5's representative which led to a further delay in urinary retention until the resident was able to be treated adequately at the hospital. -However, Resident #5's representative said she had asked for Resident #5 to be sent to the hospital earlier in the evening, more than once, because she was concerned with the possible infection in Resident #5's penis and inserting a catheter. She said she was told by the nurse and the DON that the facility could handle Resident #5's medical issues, although the physician's office had not been notified until late that night (5/12/26) of Resident #5's condition (see resident representative's interview above).

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F 0760 Level of Harm - Minimal harm or potential for 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 residents were free of significant medication errors for one (#5) of six residents reviewed for medications errors out of nine sample residents. Specifically, the facility failed to ensure Resident #5 received antibiotics for a diagnosis of a urinary tract infection (UTI) per the physician's orders.Findings include:I. Facility policy and procedure The Administration of Medications policy, dated July 2017, was provided by nursing home administrator (NHA) #1 on 5/19/26 at 4:08 p.m. The policy read in pertinent part, Medication shall be administered as prescribed by the resident's physician, nurse practitioner, or physician's assistant. Medications must be given in accordance with the resident's service plan. Medications must be administered in accordance with the written orders of the attending physician. The nurse or medication technician administering the medication must record such information on the resident's medication administration record (MAR) before administering the next resident's medication. Should a drug be withheld, refused, or given other than at the scheduled time, the staff administering must indicate the reason on the medication administration record (MAR). For those utilizing electronic medication administration records (eMAR), the appropriate code must be entered with any follow up documentation as appropriate for the situation.II. Resident #5A. Resident statusResident #5, age [AGE], was admitted on [DATE]. According to the May 2026 computerized physician orders (CPO), diagnoses included cerebral infraction, Parkinson's disease, Alzheimer's disease and neuromuscular dysfunction (affects the nerves that control voluntary muscles) of the bladder.The 3/30/26 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired with a brief interview for mental status (BIMS) score of three out of 15. The MDS assessment revealed the resident was dependent on staff for dressing, toileting hygiene, personal hygiene and transfers. The MDS assessment indicated Resident #5 was incontinent of urine and did not have a catheter at the time of the assessment. B. Record reviewA review of Resident #5's emergency room provider's note, dated 4/30/26, revealed the resident had been in the emergency room on 4/30/26, from 8:23 a.m. until 3:08 p.m.A review of Resident #5's electronic medical record (EMR) revealed the resident returned from the emergency room on 4/30/26 with a new physician's order for cephalexin capsule (antibiotic) 500 milligrams (mg), give one capsule by mouth three times a day for a urinary tract infection for seven days. -A review of Resident #5's April 2026 medication administration record (MAR) revealed the cephalexin medication was not on the MAR to be administered on 4/30/26. The 4/30/26 nursing progress note, documented at 8:55 p.m., revealed Resident #5 received the first dose of cephalexin 500 mg for the UTI.-However, the administration was not documented on the MAR (see above). The automatic medication dispensing system's transaction by item record, provided by NHA #1 on 5/19/26 at 11:23 a.m., revealed that on 4/30/26 at 8:54 p.m. one dose of cephalexin 500 mg capsule was dispensed and the quantity that remained available in the dispensing system was four capsules.A review of Resident #5's May 2026 MAR revealed Resident #5 received the ordered dose of cephalexin 500 mg capsule on 5/1/26 at 8:00 a.m.The automatic medication dispensing system's transaction by item record revealed one dose of 500 mg cephalexin capsule was dispensed on 5/1/26 at 7:38 a.m. and the quantity that remained available in the dispensing system was three capsules.A review of Resident #5's May 2026 MAR revealed Resident #5 received the ordered dose of 500 mg cephalexin capsule on 5/1/26 at 2:00 p.m.The automatic medication dispensing system's transaction by item record revealed one dose of 500 mg cephalexin was dispensed on 5/1/26 at 1:30 p.m. and the quantity that remained available in the dispensing system was two capsules.A review of Resident #5's May 2026 MAR revealed the 5/1/26 at 8:00 p.m. 500 mg cephalexin dose was not administered and was coded to see the progress note.The 5/1/26 medication administration progress note, documented at 7:35 p.m., revealed the 500 mg cephalexin capsule for Resident #5 was ordered.A review of Resident #5's May 2026 MAR revealed that on 5/2/26 at 8:00 a.m. the resident received a dose of 500 mg (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cephalexin capsule.The automatic medication dispensing system's transaction by item record revealed two doses of 500 mg cephalexin were dispensed on 5/2/26 at 9:06 a.m. and the remaining quantity available in the dispensing system was zero capsules.A review of Resident #5's May 2026 MAR revealed the resident received a dose of 500 mg cephalexin capsule on 5/2/26 at 2:00 p.m.A review of Resident #5's May 2026 MAR revealed the resident received a dose of 500 mg cephalexin capsule on 5/2/26 at 8:00 p.m.-However, according to the facility's automatic medication dispensing system's transaction by item record, there were no more 500 mg cephalexin capsules available for dispensing after the 5/2/26 9:06 a.m. transaction (see above). A review of Resident #5's May 2026 MAR revealed the resident received a dose of 500 mg cephalexin capsule on 5/3/26 at 8:00 a.m.-However, the automatic medication dispensing system's transactions by item record revealed that on 5/3/26 one dose of cephalexin 250 mg was dispensed at 8:40 a.m., which was only half the dose of the physician-ordered dose of 500 mg. A review of Resident #5's May 2026 MAR revealed the 5/3/26 2:00 p.m. dose was left blank and did not indicate if the resident received or did not receive the antibiotic administration.-However, the automatic medication dispensing system's transactions by item record revealed there were no more cephalexin capsules dispensed after the 250 mg cephalexin capsule at 8:40 a.m. on 5/3/26 (see above).A review of Resident #5's May 2026 MAR revealed the resident received a dose of 500 mg cephalexin capsule on 5/3/26 at 8:00 p.m.-However, the automatic medication dispensing system's transactions by item record revealed there were no more cephalexin capsules dispensed after the 250 mg cephalexin capsule at 8:40 a.m. on 5/3/26 (see above).A review of Resident #5's May 2026 MAR revealed the 5/4/26 at 8:00 a.m. 500 mg cephalexin dose was not administered and coded to see the progress note.The 5/4/26 medication administration progress note, documented at 7:13 a.m., revealed the 500 mg cephalexin capsule for Resident #5 was ordered. A review of Resident #5's May 2026 MAR revealed the 5/4/26 at 2:00 p.m. 500 mg cephalexin dose was not administered and coded to see the progress note. The 5/4/26 medication administration progress note, documented at 1:18 p.m., revealed the 500 mg cephalexin capsule for Resident #5 was ordered.A review of Resident #5's May 2026 MAR revealed the 5/4/26 at 8:00 p.m. 500 mg cephalexin dose was not administered and coded to see the progress note.The 5/4/26 medication administration note, documented at 8:54 p.m., revealed the facility was waiting for the delivery of the 500 mg cephalexin capsules from the pharmacy and the 500 mg cephalexin capsules were not stocked in the automatic medication dispensing system. A review of Resident #5's May 2026 MAR revealed the 5/5/26 at 8:00 a.m. 500 mg cephalexin dose was not administered and coded to see the progress note.The 5/5/26 medication administration progress note, documented at 8:09 a.m., revealed the 500 mg cephalexin capsule for Resident #5 was ordered.A review of Resident #5's May 2026 MAR revealed the 5/5/26 at 2:00 p.m. 500 mg cephalexin dose was not administered and coded to see the progress note.The 5/5/26 medication administration progress note documented at 1:06 p.m. revealed the 500 mg cephalexin capsule for Resident #5 was ordered. A review of Resident #5's May 2026 MAR revealed the resident received the 500 mg dose of cephalexin as ordered on 5/5/26 at 8:00 p.m., 5/6/26 at 8:00 a.m., 5/6/26 at 2:00 p.m., 5/7/26 at 8:00 p.m., 5/7/26 at 8:00 a.m., 5/7/26 at 2:00 p.m. and 5/7/26 at 8:00 p.m.A review of Resident #5's May 2026 MAR revealed the medication was discontinued on 5/7/26 (after the 8:00 p.m. dose), at seven days, as prescribed by the physician.-However, record review revealed Resident #5 missed 10 doses (out of 21 doses) of the physician-ordered cephalexin 500 mg capsules.-Review of Resident #5's EMR revealed no documentation to indicate that the facility had notified the physician regarding the resident's missed doses of antibiotics on 5/1/26, 5/3/26, 5/4/26 and 5/5/26.III. Staff interviews.The facility's medical director (MD), who was Resident #5's physician, was interviewed on 5/19/26 at 9:30 a.m. The MD said he would expect a call if a resident's medication was missed, especially an antibiotic. He said if he was notified, he would ask the nurse how the resident was feeling, what the resident's vital signs were and if the resident was stable. He said he would want to know when the facility expected the medication to be delivered in order to provide further instructions to the nursing staff, such as putting (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a hold on the medication until it was delivered or ordering another medication. The MD said he was not aware Resident #5 had missed so many doses of the prescribed antibiotic. He said the nursing staff should follow physician's orders and the physician should be notified of missed medications. The director of nursing (DON) and the clinical resource nurse were interviewed together on 5/19/26 at 11:30 a.m. The DON said she would expect the nursing staff to notify the physician if a resident missed a dose of medication in order to receive further instructions for that resident. The DON and the clinical resource nurse said it usually did not take several days for a medication to be delivered and could not explain why the 500 mg cephalexin was delayed for Resident #5. The DON said a blank in the MAR would indicate the medication was not administered to the resident. She said she expected her nursing staff to follow physician's orders. The DON was interviewed again on 5/19/26 at 5:15 p.m. The DON said the infection preventionist was responsible for tracking the culture and sensitivity (C&S) (a two-part laboratory (lab) procedure used to diagnose infections and to check which medications would be effective) results and tracking the antibiotic use in the facility.The pharmacy consultant was interviewed on 5/19/26 at 5:30 p.m. The pharmacy consultant said it was important for the nursing staff to follow physician's orders. She said if a medication was missed, the medication should be given as soon as possible and the physician should be notified of the missed medication. The pharmacy consultant said it was a joint effort between the medical provider and the facility to follow up on the C&S results in order to track if a resident was prescribed the correct antibiotic. She said the goal was for a resident to take all the doses of a prescribed medication.IV. Facility follow-upNHA #1 provided the following additional documentation on 5/20/26 at 4:26 p.m. (after the survey exit):Resident #5's 4/30/26 urine C&S lab results were retrieved on 5/19/26 at 6:04 p.m. The report documented the lab results were completed on 5/3/26 at 8:32 a.m. The urine C&S revealed the bacteria was enterococcus faecalis (class of bacteria) and revealed cephalexin, which was ordered for Resident #5, was not susceptible (effective) to the infection. -However, the facility did not obtain Resident #5's urine culture C&S report until after the concern for the resident's missed doses of antibiotics was brought to the facility's attention during the survey. The facility did not obtain the C&S report until after the survey exit and were not aware that the bacteria present in the resident's urine was not susceptible to the initial prescribed dose of antibiotics at the time of the survey investigation. There was no indication that the MD was made of the results.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations and interviews, the facility failed to maintain an effective infection prevention and control program to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of disease. Specifically, the facility failed to ensure Resident #5's indwelling catheter bag was not touching the floor.Findings include:I. Professional referenceAccording to the Centers for Disease Control and Prevention's (CDC) Proper Techniques For Urinary Catheter Maintenance , (4/25/24), retrieved on 5/26/26, from and https://www.cdc.gov/infection-control/hcp/cauti/summary-of-recommendations.html Keep the collecting bag below the level of the bladder at all times. Do not rest the bag on the floor. II. Facility policy and procedureThe Infection Control Policy/Procedure, dated April 2020, was provided by nursing home administrator (NHA) #1 on 5/19/26 at 4:08 p.m. It read in pertinent part, It is the policy of this facility to prevent the spread of bloodborne pathogens among healthcare workers by the direct or indirect contact with high risk of body fluids. Standard precautions are the basic level of infection control that should be used in the care of all residents all of the time. Applies to blood, all body fluids, secretions and excretions (except sweat) whether or not they contain visible blood; non-intact skin, and mucous membranes. Resident care equipment and devices - handle in a manner that prevents transfer of microorganisms to others and to the environment.III. ObservationsOn 5/18/26 at 11:50 a.m. Resident #5 was observed in the dining room with his catheter bag clipped to the underside of his wheelchair. The bottom of the catheter bag was sitting on the floor. There was approximately one to two inches of catheter tubing dragging on the floor. There was no privacy bag covering the catheter bag. On 5/18/26 at 12:15 p.m. Resident #5 was in his room. The resident's catheter bag was lying flat on the floor next to the bed. There was no privacy bag covering the catheter bag. On 5/18/26 at 1:44 p.m. Resident #5 was in his room. The resident's catheter bag had a privacy covering, however; the catheter bag was lying flat on the floor, next to the bed, with the top half of the catheter bag (where the catheter tubing entered the bag) out of the privacy bag and approximately three to four inches of the catheter tubing was lying on the floor. On 5/18/26 at 3:10 p.m. Resident # 5 was in bed with his catheter bag propped up against the bed. The bottom half of the catheter bag was out of the privacy bag and sitting on the floor mat next to the bed.IV. Staff interviewsLicensed practical nurse (LPN) #1 was interviewed on 5/18/26 at 3:22 p.m. LPN #1 said catheter bags should be checked at least every shift. She said they should be stored below the bladder and if the resident was in bed, the catheter bag should be clipped to the bed and off the floor. She said residents' catheter bags should not be touching the floor or lying on the floor for infection control reasons. LPN #1 said catheter bags should be covered for infection control and dignity purposes.The director of nursing (DON) and the clinical resource nurse were interviewed together on 5/19/26 at 11:30 a.m. The DON said catheter bags should not be placed on the floor and should be clipped to the bed or a resident's wheelchair to prevent infections.