

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 07/21/2026
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)		
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to report alleged violations of sexual abuse to the State Survey and Certification Agency in accordance with state law for two (#3 and #4) of two residents reviewed for abuse out of four sample residents. Specifically, the facility failed to ensure an incident of alleged sexual abuse between Resident #4 and Resident #3 was reported to the State Survey Agency. Findings include: Record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation on 7/21/26, resulting in the deficiency being cited as past noncompliance with a correction date of 6/15/26. I. Incident of sexual abuse on 6/6/26 On 6/6/26 a certified nurse aide (CNA) reported Resident #4 was restless all night, constantly getting up and trying to wake up her roommate, Resident #3. The CNA placed a chair outside the residents' room with the door open, so when Resident #4 got up she could lay her back in bed. After assisting another resident down the hall, the CNA returned to the chair. When she returned to the chair outside the residents' room, she heard Resident #3 saying What are you doing? The CNA entered the residents' room and saw Resident #4 sitting on the edge of her Resident #3's bed with her hand inside the brief of Resident #3. The CNA asked Resident #4 to return to her bed. However, the facility failed to report the allegation of sexual abuse to the State Agency. II. Facility plan of correction A. Immediate action to correct the deficient practice The corrective action plan the facility implemented in response to the sexual abuse incident involving Resident #4 and Resident #3 on 6/6/26 was received from the nursing home administrator (NHA) on 7/21/26 at 9:00 a.m. The corrective action plan revealed that upon notification of the sexual abuse allegation involving Resident #4 and Resident #3 that occurred on 6/6/26, the facility immediately separated both residents. Resident #4 was moved to a different room. Resident #3 was assessed by a nurse and no signs or symptoms of trauma or injury were noted. Resident #3 remained at her mood and behavior baseline and had no evidence of physical or emotional injury. On 6/6/26, the NHA initiated an investigation that included 17 residents residing on the secured unit. Based on the staff and sample residents' interviews, the NHA unsubstantiated the allegation of sexual abuse. The facility policy and procedure requires that all allegations of abuse will be reported immediately to the appropriate state agency. On 6/10/26 the facility medical director reviewed the records of alleged sexual abuse between Resident #4 and Resident #3 and documented that there appeared to be no medical issue that needed to be worked up at this time. Staff had followed up appropriately and would continue to monitor. On 6/11/26, as Resident #3's representative was packing the resident's belongings for a planned transfer to another facility, a CNA informed her of the incident that occurred with Resident #4 on the night of 6/6/26. The representative took Resident #3 to an emergency department (ED) at a local hospital for an evaluation. Resident #3's ED medical record revealed no vaginal injuries and the resident was discharged with a course of antibiotics for a urinary (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tract infection (UTI). The facility reported the alleged sexual abuse incident to the State Agency on 6/12/26 at 5:00 p.m. On 6/15/26, the NHA received one-on-one re-education on abuse investigations and reporting to the State Agency by a corporate operations manager. III. Facility policy and procedure The Reporting Alleged Violations of Abuse, Neglect, Exploitation or Mistreatment, revised December 2023, was provided by the NHA on 7/21/26 at 4:01 p.m. It read in pertinent part, If there is an allegation or suspicion of abuse, the facility will make a report to the appropriate agencies as designated by State and Federal laws. In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility will ensure that all alleged violations involving abuse, neglect, exploitations or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately but not later than two (2) hours after the allegation is made if the events that cause the allegation involves abuse or results in serious bodily injury. IV. Resident #3 (victim) A. Resident status Resident #3, age [AGE], was admitted on [DATE] and discharged on 6/11/26. According to the June 2026 computerized physician orders (CPO), diagnoses included dementia with other behavioral disturbance, anxiety disorder, personal history of transient ischemic attack (TIA) and cerebral infarction without residual deficits, and cognitive communication deficit. The 5/11/26 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of three out of 15. She was dependent on staff assistance with toileting hygiene and bathing, required substantial assistance with all transfers, and used a wheelchair for mobility. The assessment indicated the resident had wandering behavior present on four to six days during the assessment look-back period. B. Record review Resident #3's behavior care plan, initiated 9/9/24, revealed she demonstrated physical behaviors towards others, she was verbally aggressive, tearful, and voiced anxiety and distress at times. She had a history of seeing young children urinating on her bed. Interventions included analyzing key times, places, circumstances, triggers, and what de-escalated the resident's behavior and documenting, Assessing and anticipating the resident's needs, such as food, thirst, toileting needs, comfort level, body positioning and pain. -Review of Resident #3's electronic medical record (EMR) revealed no progress notes regarding the incident with Resident #4 on 6/6/26. V. Resident #4 (assailant) A. Resident status Resident #4, age [AGE], was admitted on [DATE] and re-admitted on [DATE]. According to the June 2026 CPO, diagnoses included Alzheimer's disease, unspecified dementia, unspecified severity, with other behavioral disturbance, anxiety disorder and bipolar disorder. The 4/2/26 MDS assessment revealed the resident had severe cognitive impairment with a BIMS score of four out of 15. She required substantial assistance with toileting hygiene, moderate assistance with bathing, transfers and walking with supervision. The assessment indicated the resident had wandering behavior daily during the assessment look-back period. B. Record review Resident #4's behavior care plan, initiated 10/16/25, revealed she demonstrated physical & verbal behaviors towards staff, and wandered aimlessly into other residents' rooms. Interventions included, chores like sweeping, washing dishes, or folding, non-alcoholic [NAME] mix and sweets, allow her to call her daughter or husband on the phone, sound machine in room, take for walks, allow resident to sleep in as long as desired, and redirect her when she is encroaching on the personal space of peers. On 6/6/26 a social worker documented she met with Resident #4 about an alleged incident with another resident (Resident #3). Resident #4 was in the common area with other residents listening to music. Resident #4 did not recall the alleged incident. She was observed interacting with staff and peers as per her usual routine and was displaying no signs of psychosocial or physical distress. V. Staff interviews The NHA was interviewed on 7/21/26 at 8:45 a.m. The NHA said he immediately initiated an investigation of the incident on 6/6/26 involving Resident #3 and Resident #4 after it was reported to him. He said (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the investigation included interviews with all interviewable residents in the female memory care unit. The NHA said the investigation identified there were no concerns from others about Resident #4's inappropriate behavior. He said Resident #4 worked in a healthcare profession prior to her retirement. He said the CNA who reported the incident could not explain if she observed Resident #4 touching Resident #3 inappropriately in her bikini area or if she was just touching the undergarment/brief. The NHA said the facility completed a physical and emotional assessment on both residents immediately and identified no harm or injury to either resident, therefore he did not substantiate the allegation of sexual abuse and did not report the allegation to the State Agency. The NHA was interviewed again on 7/21/26 at 2:30 p.m. The NHA said after he learned the Resident #3's representative took the resident to the ED for evaluation related to sexual abuse, he contacted his clinical resource. He said on 6/12/26 the facility initiated re-education with all facility staff members that included abuse identification, prevention and reporting. The NHA said all residents on the secured units were interviewed and family members were contacted. He said the facility initiated a plan of correction for abuse and reporting. He said the interdisciplinary team (IDT) initiated reviewing the facility's 24-hour report for any behavior or abuse concerns for all facility residents. He said the plan of correction, the Abuse Reporting policy and the facility's grievance process had been reviewed in the QAPI meeting on 6/15/26. The NHA said Resident #4 was transferred to another nursing facility per her family's choice. Registered nurse (RN) #1 was interviewed on 7/21/26 at 12:49 p.m. RN #1 said she knew Resident #4 and Resident #3 very well. She said both residents wandered around the unit and occasionally encroached on other residents' personal space, which led to verbal disputes. She said Resident #4 exhibited attachment to some staff by hugging them. She said she had not observed any inappropriate sexual behaviors for either of the residents. CNA #1 was interviewed on 7/21/26 at 1:00 p.m. CNA #1 said she worked 12-hour day shifts and knew both Resident #4 and Resident #3. She said Resident #4 was a very lovely lady who was always around the staff and in the dining room, participating in activities. She said Resident #4 liked to hug staff, but there were no incidents of her being inappropriate.		