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	01/15/2026

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure one (#1) of five residents reviewed for psychotropic medications out of 37 sample residents were as free from unnecessary medications as possible. Specifically, the facility failed to:-Ensure Resident #1 had behavior monitoring in place for antipsychotic use; and,-Ensure consents were obtained prior to administration of psychotropic medications.Findings include:I. Facility policy and procedureThe Chemical Restraints and Psychotropic Medication Management policy and procedure, revised April 2025, was provided by the regional consultant on 1/15/26 at 2:42 p.m. It read in pertinent part, It is the policy of this facility to ensure that residents are free from chemical restraints imposed for purposes of discipline or convenience or that are not required to treat a specific condition as diagnosed and documented in the clinical record. Psychotropic medications shall not be administered for the purpose of discipline or convenience. Residents who use psychotropic drugs receive gradual dose reductions (GDR), and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. The licensed nurse shall review the classification of the drug, the appropriateness of the diagnosis, its indication, behavior monitors and related adverse side effects prior to verification of admission orders with the attending physician. The social services director (SSD) and/or nursing designee will be responsible for initiating the residents' individualized, person-centered psychosocial plan of care, based on their comprehensive initial admission assessment. Upon initial comprehensive assessment, the SSD designee shall review new admissions for any psychiatric, mood or behavior disorders, mental and psychosocial difficulties, and/or physician's orders for psychotropic medications. The facility's interdisciplinary team (IDT) will review to ensure: psychotropic medication was prescribed to treat a specific diagnosed condition, as documented in the clinical record; not in excessive dosage; behavior is not related to delirium or other reversible conditions; monitoring for adverse consequences and effectiveness of medications are in place; PRN medications are within guidelines; informed consent was obtained prior to medication use; review of plan of care shows individualized, person-centered care approaches to manage behavior with non-pharmacological interventions; attempt/consider a GDR, if appropriate. II. Resident #1A. Resident statusResident #1, age [AGE], was admitted on [DATE]. According to the January 2026 computerized physician orders (CPO), diagnoses included pneumonia, chronic obstructive pulmonary disease and dementia. The 12/26/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. The MDS assessment revealed Resident #1 was dependent on staff for lower body dressing and needed partial assistance for upper body dressing and needed substantial assistance for toileting and bathing and was independent with eating. The MDS assessment further revealed Resident #1 did not have any behaviors of psychosis, verbal or physical aggression, or other behavioral symptoms such as pacing, exit seeking, rejection of care or sexual inappropriate behavior. The MDS assessment revealed Resident #1 had mild depression with a score of eight out of 27.The MDS assessment revealed Resident #1 received antidepressant, antianxiety and antipsychotic medications. B. Record reviewReview of Resident #1's January 2026 CPO revealed (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

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	01/15/2026

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the following physician's orders: Citalopram Hydrobromide (Celexa, an antidepressant medication) 20 milligram (mg) tablet. Give one tablet by mouth one time a day for depression, ordered 12/22/25. Clonazepam (an antianxiety medication) 1 mg tablet. Give one tablet by mouth in the morning for anxiety, ordered 12/22/25. Quetiapine Fumarate (Seroquel, an antipsychotic medication) 100 mg tablet. Give 100 mg by mouth at bedtime for dementia, ordered 12/22/25. Review of Resident #1's electronic medical record (EMR) revealed a psychoactive medication evaluation, dated 12/23/25 for Seroquel 100 mg. The diagnosis listed for the medication was dementia. -The evaluation did not document any behaviors for Resident #1. Resident #1's potential for a psychosocial well-being problem care plan, referring to the resident's mild depression, initiated 12/22/25 and revised 1/2/26, documented social services offered mental health counseling services which Resident #1 accepted. The interventions included allowing time for the resident to answer questions and to verbalize feelings, perceptions, and fears, providing opportunities for family to participate in care, and when conflict arose, removing the resident to a calm safe environment and allowing the resident to vent/share feelings. -The care plan failed to document specific target behaviors to monitor for Resident #1 in order to justify the use of the resident's psychotropic and antipsychotic medications. Review of Resident #1's December 2025 and January 2026 medication administration records (MAR) revealed there was no documentation for mood or behavior tracking. Review of Resident #1's December 2025 and January 2026 MARs documented tracking of sleep and side effects for the resident's antidepressant medication; however, the MARs failed to reveal side effect tracking for the resident's antipsychotic and antianxiety medications. The pharmacy consultation report, dated 1/8/26, recommended for the facility to add behavior and side effect tracking to Resident #1's MAR for the medications clonazepam, citalopram and Seroquel. -Review of Resident #1's EMR did not reveal any documentation to indicate the facility obtained consent to administer the resident's psychotropic medications. III. Staff interviewsRegistered nurse (RN) #5 was interviewed on 1/15/26 at 10:21 a.m. RN #5 said Resident #1 was on Seroquel for dementia and clonazepam for anxiety. She said the facility was monitoring the resident's hours of sleep for her antidepressant. She said Resident #1 did not have any behaviors. Director of nursing (DON) #1 was interviewed on 1/15/26 at 1:07 p.m. DON #1 said staff knew what resident behaviors to monitor for because the behavior monitoring was on the behavior tracking care plan. She said it was then documented on either the treatment administration record (TAR) or the MAR. She said once the facility was able to determine triggers and non-pharmacological interventions through observations and interviews, all of the information would be documented on the resident's care plan. She said if a resident had a behavior, the interventions for the behavior were documented on the care plan and the Kardex (a reference tool that summarizes vital resident data). She said interventions that were used during a behavioral moment and if the intervention was effective or not were documented on the TAR or the MAR. She said for Resident #1, the facility was monitoring the resident's hours of sleep for a sleep aid, and she could not find a specific behavior for the resident's antipsychotic medication. She said the facility should have triggered antipsychotic behavior. She said the facility should have documentation of the psychotropic medication consents but sometimes, they did not upload them until they could get the physical signature. -However, during the survey process, the consents were requested and the facility did not provide documentation of them.

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	01/15/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure the comprehensive care plan was reviewed and revised timely to include the instructions needed to provide effective and personalized care for one (#9) of three residents out of 37 sample residents. Specifically, the facility failed to revise Resident #9's care plan to address catheter care interventions for the prevention of recurrent urinary tract infections (UTI).Findings include: I. Facility policy and procedureThe Care Planning policy and procedure, revised March 2020, was provided by the regional consultant on 1/15/26 at 2:42 p.m. It read in pertinent part, It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive care plan for each resident. Will complete an initial care plan within 48 hours of admission. A comprehensive care plan is developed within seven (7) days of completion of the Resident Minimum Data Set (MDS) Assessment.The Catheter Care policy and procedure, revised April 2021, was provided by the regional consultant on 1/15/26 at 2:42 p.m. It read in pertinent part, It is the policy of this facility to reduce the risk of catheter- associated urinary tract infection. Use standard precautions when handling or manipulating the drainage system. Maintain clean technique when handling or manipulating catheter, tubing, or drainage bag. Empty drainage bag every shift and as needed using a graduated cylinder to measure if indicated. Certified nurse aides (CNA) may also perform catheter care and notify the nurse.II. Resident #9A. Resident statusResident #9, age [AGE], was admitted on [DATE]. According to the January 2026 computerized physician orders (CPO), diagnoses included unspecified dementia, Parkinson's disease (neurological disorder affecting movement), benign prostatic hyperplasia with lower urinary tract symptoms (enlarged prostate causing urinary issues), unspecified urethral stricture, male, unspecified site (narrowing of the male urethra) and bladder neck obstruction (blockage at the base of the bladder). The 12/5/25 minimum data set (MDS) assessment revealed Resident #9 had severe cognitive impairments with a brief interview for mental status (BIMS) score of zero out of 15. Resident #9 required partial to moderate assistance with oral hygiene, toileting hygiene, personal hygiene, and upper body dressing. Resident #9 was dependent on staff for lower-body dressing and needed substantial to maximal assistance with bathing. The assessment revealed Resident #9 had an indwelling catheter. B. Record reviewThe methenamine hippurate (non-antibiotic prescription antiseptic used for preventing UTI) care plan, revised 12/16/24, revealed the goal was for Resident #9 to be free from infection (revised 9/24/25 with a target date of 3/5/26). Interventions (revised 12/16/24) included educating the resident, family members and caregivers regarding the importance of handwashing, using soap and water and drying hands using disposable towels, encouraging fluid intakes and enhanced barrier precautions during close contact care, monitoring the resident for signs and symptoms of an active infection, obtaining and monitoring laboratory/diagnostic work as ordered and reporting results to the physician.The suprapubic catheter for obstructive and reflux uropathy care plan, revised 12/1/25, revealed the goal for Resident #9 was for the resident to show no signs or symptoms of urinary infection and remain free from catheter-related trauma (revised 9/24/25). Interventions included positioning the resident's catheter bag and tubing below the level of the bladder, changing catheter bag and tubing as ordered, discussing with resident/representative the risks and benefits of the use of a catheter, removal of the catheter when criteria for use was no longer present and the right to decline the use of the catheter, providing catheter care every shift and as needed, measuring urinary output, monitoring for signs and symptoms of discomfort on urination and frequency, urology appointments as needed and using enhanced barrier precautions. The 3/21/25 at 2:33 p.m. alert note documented Resident #9 required cues to encourage him from pulling on his catheter. The 10/16/25 at 2:40 p.m. nursing note documented Resident #9 was encouraged to not tamper with the catheter tubing.The 11/30/25 at 11:23 a.m. therapy note documented Resident #9 was being seen by speech (continued on next page)

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	01/15/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	therapy. Per IDT discussion, speech therapy would work on educating Resident #9 on catheter hygiene. The 12/1/25 at 11:14 a.m. IDT fall committee note documented part of the root cause analysis for the resident's fall was due to Resident #9's UTI. It was documented Resident #9 would often unhook and touch his catheter frequently throughout the day due to his impaired cognition and the resident did not recall staff education. The note further documented speech therapy would attempt to work on educating Resident #9 on appropriate catheter hygiene and care.The 12/2/25 at 3:30 p.m. IDT note documented barriers to Resident #9's UTI treatment were Resident #9's cognition and his frequent touching of the catheter tubing and his skin without proper hand hygiene and catheter care. The note further documented occupational therapy had done an evaluation and speech therapy was there to help with education and maintenance of hygiene and catheter care needs.The 12/4/25 at 11:49 a.m. nurse practitioner (NP) note documented Resident #9 was being seen for recurrent UTI and catheter pain. The note documented Resident #9 manipulated his catheter tubing. The 12/5/25 at 10:10 a.m. the condition follow-up note documented staff continued to assist with catheter care and reminding Resident #9 not to touch the catheter tubing and bag when witnessed.On 12/11/25 continued education was given to the staff for catheter care for Resident #9. The education provided was to continue to encourage Resident #9 to not touch his suprapubic catheter, continue to assist Resident #9 with handwashing, engage Resident #9 in activities, offer snacks to keep the resident's attention off of his catheter, encourage fluids and empty urination bag timely to prevent Resident #9 from trying to complete the task on his own.-However, Resident #9's UTI and catheter care plans failed to document the new interventions put in place to help prevent Resident #9 from touching his catheter tubing, leading to the resident's frequent UTIs (see care plans above). III. Staff interviewsCNA #3 was interviewed on 1/13/26 at 2:33 p.m. CNA #3 said Resident #9 had a catheter leg bag and CNAs would do catheter care for Resident #9 at least once every shift. She said CNAs would use alcohol swabs and clean the catheter away from his abdomen, because he had a suprapubic catheter. CNA #4 was interviewed on 1/13/26 at 3:46 p.m. CNA #4 said CNAs would do Resident #9's catheter care once a shift. She said they would use the peri care wipes to clean his tubing away from his abdomen. Registered nurse (RN) #2 was interviewed on 1/14/26 at 7:39 a.m. RN #2 said the nurses normally did the residents' catheter care. She said Resident #9 had chronic extended-spectrum beta-lactamase (ESBL), specifically E.coli. She said she normally did Resident #9's catheter care and the CNAs would do it as needed on top of what she did. The infection preventionist (IP) and director of nursing (DON) #1 were interviewed together on 1/15/25 at 10:10 a.m. The IP said she was responsible for monitoring and tracking infection trends in the facility. The IP said every resident who had an indwelling urinary catheter would also have a care plan for catheter care to prevent urinary tract infections. She said Resident #9 should have had a care plan with interventions for the nursing staff to utilize in order to prevent infections. DON #1 said all nursing staff were trained to do catheter care and used an alcohol wipe for cleaning. She said catheter care should be done at a minimum of once per 12 hour shift, or as needed. DON #1 said Resident #9 had chronic urinary tract infections because he had dementia and he continuously put his hands down his pants and touched his catheter. She said the facility encouraged staff to keep the resident's catheter bag empty, make sure Resident #9's hands were washed and clean and distract Resident #9 from putting his hands down his pants. DON #1 said all of these interventions were known by the nursing staff due to the education that was given to them. - However, the interventions were not updated on Resident #9's care plan (see care plans above).

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	01/15/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure two (#78 and #70) of three residents reviewed for pressure injuries out of 37 sample residents received care consistent with professional standards of practice to prevent pressure ulcers from developing or worsening.Specifically the facility failed to:-Ensure staff consistently offloaded Resident #78's heels; and, -Ensure staff consistently provided wound care to Resident #78 and Resident #70 in a timely manner, per physician's orders.Findings include:I. Professional reference According to the National Pressure Injury Advisory Panel, European Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance Prevention and Treatment of Pressure Injuries: Clinical Practice Guideline, third edition, [NAME] Haesler (Ed.), EPUAP/NPIAP/PPPIA (2019) retrieved on 1/20/26 from https://www.internationalguidelines.com/guideline, Pressure ulcer classification is as follows:Category/Stage 1: Nonblanchable Erythema (discoloration of the skin that did not turn white when pressed, early sign of tissue damage)Intact skin with nonblanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category/Stage 1 may be difficult to detect in individuals with dark skin tones. May indicate 'at risk' individuals (a heralding sign of risk).Category/Stage 2: Partial Thickness Skin LossPartial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising.This Category/Stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.Category/Stage 3: Full Thickness Skin LossFull thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle were not exposed. Slough may be present but did not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/ Stage 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Category/ Stage 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage 3 pressure ulcers. Bone/tendon is not visible or directly palpable.Category/Stage 4: Full Thickness Tissue LossFull thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. The depth of a Category/Stage 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Category/ Stage 4 ulcers can extend into muscle and/ or supporting structures (fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpableUnstageable: Depth UnknownFull thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category/ Stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as 'the body's natural (biological) cover' and should not be removed. Suspected Deep Tissue Injury: Depth UnknownPurple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.II. Resident #78A. Resident statusResident #78, age greater than 65, was admitted on [DATE] and readmitted on [DATE]. According to the January 2026 computerized physician orders (CPO), diagnoses included dementia, anxiety, hypothyroidism, pain and insomnia. (continued on next page)

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	01/15/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the 12/5/25 minimum data set (MDS) assessment, Resident #78 was cognitively impaired and was not able to complete a mental assessment as indicated with a brief interview for mental status (BIMS) score of zero out of 15. She required substantial/maximal assistance of two staff members for showering/bathing, dressing and transferring. The MDS assessment documented that the resident was at risk of developing pressure ulcers and had an unstageable pressure ulcer on her right heel that was not present upon admission or reentry.B. ObservationsOn 1/14/26 at 9:15 a.m. Resident #78 was lying on her right side in bed. Two foam heel booties were observed in the resident's closet in her room. The resident was lying on an air mattress and did not have heel protection devices on either of her feet.-However, the resident's care plan indicated to float her heels as tolerated. Additionally, the resident's care plan was not updated to indicate the resident had an air mattress (see care plan below).On 1/14/26 at 9:20 a.m. Resident #78's wound care was observed with the assistant director of nursing (ADON) and certified nurse aide (CNA) #6. After the ADON removed the resident's socks, Resident #78 was noted to have a black necrotic area (dead tissue) on her right heel. There was no wound care dressing covering the resident's right heel when the ADON removed the resident's socks. -However, according to the resident's January 2026 CPO, Resident #78 should have a protective dressing on her right heel (see physician's orders below). C. Record reviewA skin assessment, dated 1/3/26, documented Resident #78 was admitted without any pressure injuries to her heels measuring a length of 0.5 centimeters (cm) and width of 0.4 cm. The skin assessment indicated the resident's right heel wound onset date was 11/23/25. Review of Resident #78's January 2026 CPO revealed the following physician's orders:Wound care for right heel: Cleanse right heel area, pat dry, apply hydrocolloid dressing. Change once weekly on Fridays and as needed if dislodged, ordered 12/12/25. -However, there was no dressing on Resident #78's right heel when wound care was performed (see observation above). Encourage resident to offload heels and side to side position while in bed, ordered 7/19/25.-However, Resident #78's heels were noted to be positioned directly onto her air mattress and not offloaded on 1/14/26 (see observations above). Resident #78's skin integrity care plan, initiated 11/14/24, revealed Resident #78 had potential for pressure ulcer development related to disease process and immobility. Pertinent interventions included floating heels as necessary, encouraging the resident to turn and reposition and providing assistance as needed and administering treatments as ordered and monitoring for effectiveness. -The staff failed to consistently implement the interventions on the care plan for protection of the resident's heels (see observations above). III. Resident #70A. Resident statusResident #70, age greater than 65, was admitted on [DATE]. According to the January 2026 CPO, diagnoses included hypertension, chronic kidney disease, anxiety, depression and transient ischemic attack. According to the 10/23/25 MDS assessment, Resident #70 was severely cognitively impaired and was not able to complete a mental assessment as indicated with a brief interview for mental status (BIMS) score of zero out of 15. He required substantial/maximal assistance of two staff members for showering/bathing, dressing and transferring. The MDS assessment documented that the resident was at risk of developing pressure ulcers and had an unstageable pressure ulcer that was not present upon admission or reentry.B. ObservationsOn 1/13/26 at 2:03 p.m. Resident #70's right heel wound care was observed with registered nurse (RN) #6. The wound dressing on the resident's right heel was dated 1/9/26, indicating wound care had not been provided to the resident for four days. -However, the physician's orders for wound care instructed the nursing staff to change the wound dressing daily (see physician's orders below). C. Record review Review of Resident #70's January 2026 CPO revealed the following physician's order:Wound care orders to right heel: Cleanse area to right heel, pat dry, cover wound bed with xeroform to fit and cover with bordered gauze daily and as needed, ordered 1/9/26.-However, the resident's dressing had not been changed since 1/9/26, a four-day period (see observations above).Resident #70's skin integrity care plan, initiated 11/5/25, revealed the resident had an actual impairment to skin integrity related to a stage 3 ulcer to right heel and an abrasion to left lateral malleolus (ankle bone). Pertinent interventions included administering treatments as (continued on next page)

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	01/15/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ordered, enhanced barrier precautions, pressure reducing mattress and cushion and wound rounds to follow weekly as needed (initiated 11/12/25). IV. Staff interviews. RN #6 was interviewed on 1/13/26 at 2:10 p.m. RN #6 said Resident #70 had a physician's order for his wound care dressing to be changed every day during the day shift, or as needed. She said the resident's' dressing on his right heel should have been completed on the prior day shift (1/12/26) by the on-duty nurse. RN #6 said the resident often declined to wear his offloading boots. RN #6 said she typically did not have a problem completing wound care for the residents. She said there were plenty of staff members working during the day to help with wound care dressings if it were needed. CNA #6 was interviewed on 1/14/26 at 9:25 a.m. CNA #6 said Resident #78 was very weak and frail and was currently on hospice services. She said the nursing staff tried to make the resident comfortable by repositioning her and assisting her with eating and bathing hygiene. CNA #6 said the resident had dressings on her body to prevent her from acquiring worsening wounds. She said if she noticed any dressings that were missing, she was instructed to notify the nursing staff. CNA #6 said the resident should have her offloading boots on while in bed because the resident was unable to reposition herself.Director of nursing (DON) #1, the assistant director of nursing (ADON) and the regional consultant were interviewed together on 1/14/26 at 10:43 a.m. The ADON said she was not wound care certified, but worked as the wound care nurse for the facility on a full-time basis Monday through Friday. The ADON said her duties included conducting wound care audits, weekly skin check documentation audits of the nursing staff, completing resident admission documentation and completing weekly rounds with a wound care physician. The ADON said the nursing staff were responsible for completing daily dressing changes and skin assessments for the residents. The ADON said the dressing for Resident #70 should have been completed daily according to the physician's order. The ADON said Resident #78 should have had a dressing applied to her right heel. The ADON said Resident #78's heels needed to be off loaded in order to prevent the resident's heel wound from worsening. DON #1 said she would provide staff training regarding adhering to physician's orders, specifically regarding wound care. DON #1 said the nursing staff would often be extremely busy with other resident care duties. DON #1 said the reason why Resident #70 and Resident #78 did not have timely wound care completed could have been the result of the nurses being extremely busy. DON #1 said it was the nurse's responsibility to reach out for assistance to the administrative staff to get all nursing duties completed, including wound care. The regional consultant said it would be critically important for the nursing staff to follow the physician's orders regarding wound care to prevent infections or additional wound development. The regional consultant said Resident #70 was often non-compliant with his wound care dressing, and the facility failed to add this information to the resident's care plan. The regional consultant said she would update the resident's care plan today (1/14/26).

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	01/15/2026

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure residents who required dialysis services received such services consistent with professional standards of practice for one (#10) of one resident reviewed for dialysis out of 37 sample residents. Specifically, the facility failed to consistently complete the communication form used for dialysis communication for Resident #10Findings include:I. Facility policy and procedureThe Dialysis (Renal), Pre and Post-Care policy and procedure, revised April 2025, was received from the regional consultant on 1/15/26 at 9:02 a.m. It read in pertinent part, Assist resident in maintaining homeostasis pre- and post-renal dialysis; assess and maintain patency of renal dialysis access; assess resident daily for function related to renal dialysis; participate in ongoing communication and collaboration with the dialysis facility regarding dialysis care and services. Assess resident's blood pressure (in non-fistula arm) prior to being transported to the dialysis unit. Any staff concerns about resident's condition that may influence the dialysis treatment should be addressed prior to leaving skilled facility as the resident may need to be assessed in an emergency room. Dialysis access should be assessed upon return to the facility for patency, any unusual redness, swelling, or bleeding. Any significant change in medical condition should be reported immediately. Report any fever, unusual fatigue or weakness, shortness of breath, unusual pain, sleeplessness, chest pain, somnolence or any deviation from the resident's norm. The care of the resident receiving dialysis services will reflect ongoing communication, coordination and collaboration between the nursing home and dialysis staff. Documentation related to pre- and post-dialysis care will be placed in the clinical record and include: resident assessments, interventions, and any provided education. Assessment of renal dialysis access site, to include presence or absence and quality of a bruit and thrill for residents with an arteriovenous fistula. Communication between facility and dialysis staff or medical provider.II. Resident #10 A. Resident statusResident #10, age less than 65, was admitted on [DATE]. According to the January 2026 computerized physician orders (CPO), diagnoses included other disorders of electrolyte and fluid balance, end stage renal disease (abnormal kidney function), type two diabetes (abnormal glucose control). The 1/2/26 minimum data set (MDS) assessment revealed Resident #10 had moderate cognitive impairments with a brief interview for mental status (BIMS) score of eight out of 15. The MDS assessment revealed Resident #10 was dependent on staff for transfers, and lower body dressing and needed substantial to maximal assistance with upper body dressing, toileting, and bathing. The MDS assessment revealed Resident #10 had renal insufficiency, renal failure, or end stage renal disease (ESRD).B. Record reviewThe dialysis communication for Resident #10, from 12/23/25 (the date of the resident's admission to the facility) through 1/14/26, was provided by nursing home administrator (NHA) #3 on 1/14/26 at 2:16 p.m. Review of the communication revealed three dialysis communication forms, dated 1/1/26, 1/6/26 and 1/13/26.-The 1/1/26 dialysis communication form did not document what medications were administered to Resident #10 prior to dialysis treatment. -The 1/6/26 dialysis communication form did not document a pre-dialysis weight for Resident #10.The 1/13/26 dialysis communication form had all information documented completely on the form.-There were no further dialysis communication forms from 12/23/25 through 1/14/26 provided by the facility. On 1/16/26, after the survey exit, the facility provided additional dialysis communication forms for Resident #10 for 12/27/25, 12/30/25, 1/3/26, 1.8/26 and 1/9/26. The additional dialysis communication forms revealed the following:-The 12/27/25 dialysis communication form did not document what medications were administered to Resident #10 and was not signed by the nurse.-The 12/30/25 dialysis communication form did not document a pre-dialysis weight for Resident #10.-The 1/3/26 dialysis communication form did not document what medications were administered to Resident #10 prior to dialysis and was not signed by the nurse.-The 1/8/26 dialysis communication form did not document what medications were administered to Resident #10 (continued on next page)

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	01/15/2026

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prior to dialysis. -The 1/9/26 dialysis communication form did not document a pre-dialysis weight for Resident #10, did not document what medications were administered to the resident prior to dialysis and was not signed by the nurse.-Additionally, none of the dialysis communication forms provided after the survey exit included the information from the dialysis center on them. III. Staff interviewsLicensed practical nurse (LPN) #1 was interviewed on 1/14/26 at 1:08 p.m. LPN #1 said the facility was using a communication sheet for dialysis communication instead of a notebook. She said the facility would send the communication sheet in a folder to dialysis with the resident. She said the facility filled out the top half of the sheet and the dialysis center filled out the bottom portion. LPN #1 said when the resident came back from dialysis, the medical records staff would upload the form into the resident's electronic medical record (EMR). The dialysis registered nurse (RN) was interviewed on 1/14/26 at 1:55 p.m. The dialysis RN said she had been working with Resident #10 since before she was admitted to the facility. She said communication with the facility was difficult. She said the facility did not get back to the dialysis center timely. She said the communication form was often not filled out completely. She said most of the time the facility would only fill out the resident's last vital signs and her diet. She said the facility should be completing the pre-dialysis weight, what medications were administered to the resident prior to dialysis, vital signs and if there was any change in condition for the resident. The dialysis RN said there was a transportation issue on 1/8/26. She said once Resident #10 was finished with her dialysis treatment, no one from the facility was there to pick her up. She said the facility refused to pick her up. She said it took calling the non-emergent paramedics and having them convince the facility to pick the resident up. She said Resident #1 was at the dialysis center for an extra hour and a half to two hours on 1/8/26 because of the transportation issue. She said that on 1/9/26 Resident #10's treatment was delayed two hours due to the facility forgetting to send her sling for transfers. She said the dialysis center had to call numerous times for the facility to pick up the phone. She said best practice for good communication had been having one point of contact, which was usually the transportation person unless it was high critical needs. RN #5 was interviewed on 1/15/26 at 10:21 a.m. RN #5 said the process for sending a resident to dialysis included administering medications to the resident, taking their vital signs and obtaining their pre-dialysis weight. She said the nurse would write down the resident's weight and vital signs on the dialysis communication sheet. She said that when the resident came back from dialysis, the nurse would take the resident's vital signs again and check the resident's dialysis access site. She said for Resident #1, she would check the resident's bruit and thrill as well). She said she was unsure if the nurses were supposed to obtain a post-dialysis weight when the resident came back from dialysis. Director of nursing (DON) #1 was interviewed on 1/15/26 at 1:07 p.m. DON #1 said staff knew who had dialysis because there was a physician's order with the resident's dialysis chair time, the days the resident went to dialysis and which dialysis center the resident went to. She said that when a resident went to dialysis, the facility would send the dialysis communication form with the resident. DON #1 said the communication form had the resident's vital signs and pre-dialysis weight documented on it and then the dialysis center would fill out their portion of the form and send it back with the resident. She said the resident's primary nurse for the day was responsible for filling out the dialysis communication form and the dialysis center was responsible for filling out their portion. She said the communication form was then uploaded into the resident's EMR upon the resident's return from the dialysis center. She said the dialysis center would talk to the charge nurse when they called or if the charge nurse was not available, the dialysis center would talk to the DON.DON #1 said she did hear about the transportation issue that had happened on 1/8/26 with Resident #10. She said when Resident #10 was living in the community, her family would cancel her rides, so the transportation company had canceled her service. She said the facility had been working on setting up a new transportation company but the facility van driver had been filling in until they got everything worked out. She said for the missing dialysis communication sheets for the days that Resident #10 went to dialysis, she said the dialysis center did not send the communication sheets (continued on next page)

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	01/15/2026

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	back. She said when the dialysis center did not send the communication forms back, she would request the treatment details and they would send them over.

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	01/15/2026

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 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 ensure infection prevention and control programs (IPCP) were maintained and followed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections on two of four units. Specifically, the facility failed to: -Ensure staff followed appropriate hand hygiene and gown changes while performing wound care for Resident #61; and,-Ensure staff wore the appropriate personal protective equipment (PPE) when providing incontinence care and transfers for Resident #70, who was on enhanced barrier precautions (EBP) for wounds.Findings include:I. Failed to ensure staff performed appropriate hand hygiene and gown changes while providing wound care for Resident #61A. Facility policy and procedureThe infection Control policy, undated, was received from nursing home administrator (NHA) #1 on 1/12/26 at 10:26 a.m. The policy read in pertinent part, It is the policy of this facility to prevent the spread of bloodborne pathogens among healthcare workers by direct or indirect contact with high risk body fluids. Hand hygiene is required following any resident contact, after touching blood, body fluids, secretions, excretions, contaminated items; immediately after removing gloves, and between resident contacts. Avoid unnecessary touching of surfaces in close proximity to the resident to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces. Remove gloves promptly after use and discard before touching non-contaminated items or environmental surfaces, and before providing care to another resident. Wash hands immediately after removing gloves.B. Resident interviewResident #61 was interviewed on 1/14/26 at 7:45 a.m. Resident #61 said she was admitted to the facility last month for wound care and recovery. She said her wound care involved a wound vac and it was done on Mondays, Wednesdays, and Fridays. She said the nursing staff would wear gloves and a mask when providing her with wound care. She said the nursing staff did not always wear gowns when doing her wound care. She said she did not know if the nursing staff were required to wear a gown during wound care.C. ObservationsOn 1/14/26 at 2:00 p.m. there was a sign on Resident #61's door that indicated she was on EBP. The sign on the resident's door indicated gloves and a gown must be worn for resident care activities, including dressing, bathing/showering, transferring, linen changes, providing hygiene, changing briefs or assisting with toileting and device care or use, such as central lines, urinary catheters, feeding tubes, tracheostomies and wound care. On 1/14/26 at 2:12 p.m., during completion of wound care for Resident #61, the assistant director of nursing (ADON) touched the resident's dresser dresser drawer to retrieve barrier pads to use during wound care while wearing gloves. After touching the resident's dresser drawer with her gloved hands, the ADON proceeded with the resident's wound care without changing her gloves or performing hand hygiene. The ADON was immediately notified of the observations made of her contaminating her gloves by touching the resident's furniture. The ADON said she did not realize what she was doing at the moment and proceeded to remove the dirty gloves, perform hand hygiene with hand sanitizer and put on new clean gloves. On 1/14/26 at 2:14 p.m. an unidentified staff member donned gloves and a gown to assist the ADON with wound care for Resident #61. The unidentified staff member failed to change his gown after rubbing his face on his left arm twice during the wound care. The unidentified staff member was notified of the observation. He said he should not have rubbed his face on the clean gown because of the risk of spreading bacteria. The unidentified staff member proceeded to remove his gown and put on a clean new gown to continue assisting with the ADON with Resident #61's wound care.II. Failed to ensure staff wore the appropriate PPE when providing incontinence care and transfers for Resident #70, who was on EBP for open wounds on his left foot. A. Professional referenceAccording to the Centers for Disease Control and Prevention's (CDC) Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), retrieved on 1/18/26 from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html,Enhanced barrier (continued on next page)

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	01/15/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact resident care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when contact precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization, as well as for residents with MDRO infection or colonization. Examples of high-contact resident care activities requiring gown and glove use for enhanced barrier precautions include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator) and wound care, any skin opening requiring a dressing.B. Observations On 1/12/26 at 10:25 a.m. there was a sign on Resident #70's door that indicated the resident was on EBP. The sign on the resident's door indicated gloves and a gown must be worn for resident care activities, including dressing, bathing/showering, transferring, linen changes, providing hygiene, changing briefs or assisting with toileting and device care or use, such as central lines, urinary catheters, feeding tubes, tracheostomies and wound care. On 1/14/26 at 6:53 a.m. certified nurse aide (CNA) #7 was assisting Resident #70, with a toilet to chair transfer. CNA #7 had gloves on, but failed to don a gown while providing direct care to Resident #70. III. Staff interviews CNA #5 was interviewed on 1/13/26 at 8:47 a.m. CNA #5 said she picked up shifts often at the facility through a staffing agency. She said she did not receive any specific training from the facility regarding resident care or facility policy. She said it was typical not to receive any training from the facility as an agency CNA. She said she understood infection control precautions from previous training at other facilities. She said her understanding of EBP was that staff were to wear gowns and gloves when a resident had an indwelling foley catheter, open wounds, indwelling devices or other high contact care such as transferring, dressing and linen changes.CNA #7 was interviewed on 1/14/26 at 7:00 a.m. CNA #7 said she did not wear a gown while providing care for Resident #70 because she did not know he was on precautions. She said she did not recall receiving any specific education regarding EBP from the facility. She said she knew Resident #70 had wounds on his feet, but thought she was only required to wear gloves while providing care. Licensed practical nurse (LPN) #2 was interviewed on 1/14/26 at 8:30 a.m. LPN #2 said any resident with an indwelling foley catheter or open wound required gowns and gloves for nursing staff to perform care. The infection preventionist (IP) and director of nursing (DON) #1 were interviewed together on 1/15/26 at 10:10 a.m. The IP said she was responsible for monitoring and tracking infection trends in the facility. The IP said it was very important to adhere to infection control standards while providing care to residents to minimize the spread of bacteria. The IP said all nursing staff in the facility were provided education regarding EBP during new employee orientation. The IP said she also provided infection control education quarterly to all nursing staff. The IP said she would start to conduct more audits and education for the nursing staff regarding preventing the spread of bacteria through transmission based precautions.DON #1 said the ADON was very nervous while being observed performing wound care for Resident #61. DON #1 said she would immediately provide education to both the ADON and the unidentified staff member, along with the rest of the direct care nursing staff regarding infection control protocol with hand hygiene and gown changes. DON #1 said Resident #61 was at a high risk of getting an infection because she had a very complicated wound. DON #1 said the importance of maintaining strict transmission based precautions was critical to prevent Resident #61 and Resident #70 from acquiring an infection.

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	01/15/2026

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to develop an antibiotic stewardship program that promotes the appropriate use of antibiotics and includes a system of monitoring to improve resident outcomes and reduce antibiotic resistance for one (#8) of five residents out of 37 sample residents. Specifically, the facility failed to ensure clinical signs and symptoms of side effects and adverse reactions were monitored and identified for Resident #8 while the resident was receiving prescribed antibiotics.Findings include:I. Professional referenceThe Centers for Disease Control and Prevention's (CDC) Antibiotic Prescribing and Usage in Hospitals and Long-term Care, dated 2019, was retrieved on 1/16/26 from https://www.cdc.gov/antibiotic-use/hcp/core-elements/hospital.html. It read in pertinent part,Implement policies that apply in all situations to support antibiotic prescribing to include specifying the dose, duration and indication for all courses of antibiotics so that they are readily identifiable. Implement facility specific treatment recommendations, based upon the national guidelines and local susceptibilities and formulary options that optimizes antibiotic selections, duration, and common indications for the usage of community acquired pneumonia, urinary tract infections, skin and soft tissue infections.II. Facility policy and procedureThe Antibiotic Stewardship policy, dated September 2017, was received from nursing home administrator (NHA) #1 on 1/12/26 at 10:26 a.m. The policy read in pertinent part, It is the policy of this facility to implement an Antibiotic Stewardship Program (ASP) that is incorporated in the overall Infection Prevention and Control Program which will promote appropriate use of antibiotics while optimizing the treatment of infections, at the same time reducing the possible adverse events associated with antibiotic use. This policy has the potential to limit antibiotic resistance in the post-acute care setting, while improving treatment efficacy and resident safety, and reducing treatment-related costs. The team will review data, monitor and summarize antibiotic use from pharmacy data, such as the rate of new starts, types of antibiotics prescribed, or days of antibiotic treatment per 1,000 resident days. Summarize antibiotic resistance patterns based on laboratory data. Incorporate monitoring of antibiotic use, including the frequency of monitoring/review. Report on the number of antibiotics prescribed and the number of residents treated each month and assess residents for any infection using McGeer's criteria.III. Resident #8 A. Resident statusResident #8, age less than 65, was admitted on [DATE] and readmitted on [DATE]. According to the January 2026 computerized physician orders (CPO), diagnoses included obstructive uropathy (a condition where urine flow is blocked, causing a backup of urine into the kidneys), dementia, transient ischemic attack (TIA), epilepsy and spinal stenosis. According to the 11/24/25 minimum data set (MDS) assessment, Resident #8 had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 11 out of 15. He was dependent on staff assistance and required two or more staff members for toileting hygiene, dressing and bathing. The MDS assessment revealed the resident was receiving an antibiotic medication and had an indwelling urinary catheter.B. Resident interview Resident #8 was interviewed on 1/13/26 at 1:30 p.m. Resident #8 said he did not eat by mouth because he had the gastrostomy feeding tube (G-tube) R said he had a catheter because he retained urine. Resident #8 did not think he had any infections but was aware he was taking an antibiotic medication. He said he did not know what side effects of the medication to watch for. C. Record review Review of Resident #8's January 2026 CPO revealed the following physician's order:Cefuroxime Axetil (antibiotic) oral tablet 500 milligrams (mg). Give one tablet by G-tube two times a day for urinary tract infection (UTI) for three days, ordered 1/13/26.Review of Resident #8's electronic medical record (EMR) revealed alert charting to monitor the resident's urinary tract infection. The monitoring included abnormal urine color, cloudy urine, hematuria (blood in the urine) and bladder spasms.-There was no documentation in the resident's EMR to indicate antibiotic side effects were consistently being reviewed and monitored. Resident #8's (continued on next page)

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	01/15/2026

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	infection care plan revealed he had a risk for infection related to indwelling devices, including a suprapubic catheter and an internal feeding device (initiated 9/10/24). Interventions included enhanced barrier precautions, monitoring for signs and symptoms of infection, monitoring vital signs and educating the resident, family and caregivers regarding the importance of hand washing. -However, the resident's care plan revealed no specific interventions for caregivers to monitor for side effects related to the use of antibiotics. IV. Staff interviews Certified nurse aid (CNA) #8 was interviewed on 1/11/26 at 2:02 p.m. She said she worked at the facility through a staffing agency. She said the long-term hall residents required mechanical lifts, incontinence care, and fall risk monitoring. She said she did not do any monitoring for antibiotics for Resident #8 because that was not her role. She said if she noticed any behavior that was unusual for any residents, she would report it to the floor nurses. She said some days the nursing staff would work with not enough help. She said if she worked shorthanded, it would affect her ability to provide care and notice changes in the residents. \Licensed practical nurse (LPN) #2 was interviewed on 1/14/26 at 8:30 a.m. LPN #2 said the nurses were responsible for performing catheter care for the residents every shift. She said Resident #8 was on an antibiotic for a urinary tract infection. She said the nursing staff would monitor the resident to make sure the antibiotic was effective. She said the nursing staff would also monitor for side effects of taking the antibiotics. She said side effects of taking antibiotics included nausea, vomiting or upset stomach. She said the nurses would document the side effects of the antibiotic in the nursing progress notes.-However, there was no documentation in Resident #8's EMR to indicate side effects of the antibiotic medication were being monitored for the resident (see record review above). The infection preventionist (IP) and director of nursing (DON) #1 were interviewed together on 1/15/26 at 10:10 a.m. The IP said She is responsible for monitoring and tracking infection trends in the facility. The IP said every resident who has an indwelling urinary catheter would also have a care plan for catheter care to prevent urinary tract infection. The IP said if a resident was on antibiotics for an infection, the nurses would monitor for the effectiveness of the antibiotic, in addition to adverse reactions to the antibiotic. She said this monitoring would be documented in the residents' EMR. She said all residents who were taking antibiotics should have a care plan with interventions for the nursing staff to utilize. DON #1 said Resident #8 received an order from the physician for an additional three days of antibiotic therapy for his urinary tract infection. She said the nurses were aware of the need to monitor for and document adverse reactions while residents were receiving antibiotics. She said there was no monitoring documentation placed in Resident #8's EMR. She said she assumed that the nurses would document this information in the progress notes. She said she would make sure all residents who were on antibiotics had specific antibiotic adverse reaction monitoring documentation. DON #1 said it was always important to monitor when residents were taking short-term antibiotics to prevent unwanted side effects.