STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315508	A. Building B. Wing	07/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pelican Pointe Post Acute Nursing & Rehabilitation	3809 Bayshore Road North Cape May, NJ 08204

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observations, interviews, medical record review, and review of other pertinent facility documentation on 07/14/2025 and 07/15/2025 it was determined that the facility failed to develop a comprehensive person-centered care plan (CP), and failed to follow the facility Licensed Practical Nurse (LPN), Registered Nurse (RN) and Unit Manager (UM) job descriptions for 1 of 3 residents (Resident #3) reviewed for CPs.This deficient practice was evidenced by the following:According to the admission Record (AR), Resident #3 was admitted to the facility with diagnoses which included but were not limited to hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (a condition where blood flow to the brain is blocked, depriving brain cells of oxygen) affecting right dominant hand; muscle weakness; other abnormalities of gait and mobility; cognitive communication deficit; and noninfective gastroenteritis and colitis, unspecified. According to the Minimum Data Set (MDS), an assessment tool, dated 04/23/2025, Resident #3 had a Brief Interview for Mental Status (BIMS) of 11 out of 15, indicating that the resident's cognition was moderately impaired. The MDS revealed that Resident #3 required substantial/maximal assistance with toileting hygiene, was dependent for toilet transfers, and was frequently incontinent of urine and stool. A review of Resident #3's progress note (PN) dated 06/04/2025 at 11:41 P.M., revealed that the resident had loose stools and received anti-diarrhea medication. A PN dated 06/06/2025 at 2:04 A.M., revealed that Resident #3 had, extensive loose bowel x2 with a foul smell. A PN dated 06/06/2025 at 12:25 P.M. revealed that a physician was contacted due to Resident #3 complaints of chronic diarrhea and lab studies were ordered. A PN dated 06/08/2025 at 7:47 A. M., revealed, Resident sent to ER for loose stools per residents' request. A PN dated 06/08/2025 at 2:51 P.M. , revealed that Resident #3 returned from the hospital with a diagnosis of colitis with the recommendation to begin antibiotic treatment. A PN dated 06/17/2025 at 12:32 P.M., revealed [.] reviewed stool bulking food items. [family member] requested appointment with GI [gastroenterology] be moved up [.]. A PN dated 06/21/2025 at 5:55 P.M., revealed that Resident #3 had loose stools and that anti-diarrhea medication was given with positive results. A PN dated 07/11/2025 at 3:41 P.M., revealed that Resident #3 had 4 episodes of diarrhea and received antidiarrheal medication. The same PN revealed that a medication with a side effect of diarrhea was discontinued per doctor's orders. Review of Resident #3's Order Summary Report revealed orders for the following medications:Loperamide HCl Capsule (medication used to treat diarrhea) 2 MG, give 1 capsule by mouth every 8 hours as needed for diarrhea after each loose stool. The order date was 05/23/2025.Lomotil tablet (medication used to treat diarrhea) 2.5-0.025 MG, give 2 tablets by mouth every 4 hours as needed for diarrhea no more than 8 tabs daily. The order date was 06/13/2025.GlycoLax Powder (medication used for the treatment of constipation), Give 17 gram by mouth every 24 hours as needed for constipation. The order date was 04/17/2025. The order was discontinued on 05/23/2025. Review of Resident #3's Medication Administration Record revealed that Resident #3 received 54 doses of as needed diarrhea medications during the months of May, June, and July 2025. Review of Resident #3's CP revealed no Focus, Goals, or Interventions addressing Resident #3's diagnosis of colitis or the resident's diarrhea. An interview was conducted with LPN #1 on 07/15/2025 at 3:56 P.M. LPN #1 stated that Resident #3 had ongoing diarrhea, was diagnosed with colitis, has been seen by a Gastroenterologist, and had an upcoming follow-up appointment for a colonoscopy. During the same interview LPN #1 stated that the process when a resident developed a new issue was for staff to make their leadership during huddles. LPN #1 stated that UMs, the MDS Coordinator, or the Director of Nursing (DON) updated resident CPs. LPN #1 further stated that staff referred to the CP to know what care the resident required and that it was important to add new issues to the CP when the arouse. An interview was conducted with UM #1 on 07/15/2025 at 4:08 P.M. UM #1 stated that CPs were intended to ensure that residents received the care they needed, and that CPs were where, everything comes together. UM #1 stated that Nurses, UMs, MDS Coordinators, and Social Services could all update CPs and the expectation was that CPs were updated when new issues arouse. UM #1 stated that typically, it was the responsibility of the UM to ensure that CPs were updated. UM #1 stated that if a CP was not updated issues might be missed, the care provided would not be reflected, and lack of communication could occur. During the same interview UM #1 stated that she was aware the Resident #3 had been having diarrhea since she (UM #1) began working at the facility on 06/10/2025. Resident #3's CP was reviewed with UM #1. UM #1 confirmed that the CP contained no Focus, or Interventions, related the resident's diarrhea. An interview was conducted with the facility's DON on 07/15/2025 at 5:30 P.M. The DON