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 _____	C 03/24/2025

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**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

Standard Survey: 03/18/2025 to 03/24/2025

Census: 115

Sample Size: 23 + 3 closed records

Complaint #: NJ 165588, 166015, 174178, 180316, 183137, 183417, 183485

A Recertification/LSC survey was conducted from 03/18/2025 through 03/24/2025, to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities.

During the survey, a finding which constituted an Immediate Jeopardy (IJ) was identified under 42 CFR 483.25(d)(2) F 689 as the facility failed to ensure a NJ Exec Order 26.4b1 resident with a known history of NJ Exec Order 26.4b1 from the facility on NJ Exec Order 26.4b1 Resident #12, who wore a NJ Exec Order 26.4b1 that the physician ordered to be checked every shift for NJ Exec Order 26.4b1 and NJ Exec Order 26.4b was last checked on NJ Exec Order 26.4b1 was last seen by staff on NJ Exec Order 26.4b1 at 6:15 AM. On NJ Ex Order 26.4b1 at 6:39 AM, the NJ Exec Order 26.4b1 called the facility to report that Resident #12 was NJ Exec Order 26.4b1 the facility's NJ Exec Order 26.4b1 at the NJ Exec Order 26.4b1. Resident #12 was NJ Exec Order 26.4b to the facility by Emergency Medical Technicians (EMT) at approximately 7:15 AM. At that time, a NJ Exec Order 26.4b1 was completed on Resident #12 with NJ Exec Order 26.4b1

The facility's failure to provide adequate supervision to a NJ Exec Order 26.4b1 resident who

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/12/2025

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.

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F 000	Continued From page 1	F 000		

was at risk for [NJ Exec Order 26.4b1] and [NJ Exec Order 2] posed the likelihood of serious harm, injury, impairment, or death. This resulted in an Immediate Jeopardy (IJ) situation.

The IJ began on [NJ Exec Order 26.4b1] at 6:15 AM, when Resident #12 [NJ Exec Order 26.4b1]. The facility submitted an acceptable Removal Plan (RP) on 3/21/2025. The survey team verified the implementation of the RP during the continuation of the on-site survey on 3/21/2025.

A Partial Extended Survey was initiated after the deficiency was identified at the IJ/SQC (substandard quality care) level.

The facility's Administration was notified of the F 689 IJ and was provided with the IJ Template on 3/20/2025 at 3:15 PM.

An acceptable RP was received on 3/21/2025 at 10:48 AM, which indicated the action the facility took to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice including; Resident #12's [NJ Ex Ord] was assessed [NJ Exec Order 26.4b1], their [NJ Exec Order 26.4b1] was checked for [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1] without identified issues, Resident #12 was seen by [NJ Exec Order 26.4b1] services within twenty-four hours [NJ Ex Order 26.4] [redacted] modifications and their plan of care was updated after interdisciplinary team review, the [NJ Exec Order 26.4b1] was monitored by rotating staff pending vendor arrival, the [US FOIA] conducted a house wide audit of all doors to ensure the [NJ Exec Order 26.4b1] system was [NJ Exec Order 26.4b1] the [US FOIA (b)(6)])/designee performed a house wide audit of all residents at risk for [NJ Exec Order 26.4b1] to ensure appropriate

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F 000	Continued From page 2 monitoring was in place, the [US FOIA (b)] and [US FOIA (b)] completed education and initiated competencies on facility's "Elopement Policy." The survey team verified the implementation of the RP during the continuation of the on-site survey on 3/21/2025.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to maintain a homelike environment that accommodated the resident needs and preferences. This deficient practice was identified for 1 of 23 residents reviewed (Resident# 311) and was evidenced by the following: During the initial tour of the facility on 03/18/2025 at 10:04 AM, the surveyor observed Resident #311in bed with [NJ Exec Order 26.4b1] and the [NJ Exec Order 26.4] The surveyor noted that Resident #311 [NJ Exec Order 26.4b1] of the bed and [NJ Exec Order 26.4b1] towards the [NJ Exec Order 26.4] [NJ Exec Order 26.4b1] When asked if Resident #311 was they stated that they have asked for the [NJ Exec Order 26.4b1] when they entered but nothing was done about it.	F 558	Element One- Corrective Actions An [NJ Exec Order 26.4b] was placed on the bed of Resident #311 on [NJ Exec Order 26.4]. Nursing staff who provide care to Resident #311 received re-education to check that the [NJ Exec Order 26.4b] is in place and provides the needed [NJ Exec Order] for the [NJ Exec Order 26.4] of Resident #311. Element Two- Identification of at Risk Residents Residents who are tall and require bed extenders have the potential to be affected by this practice. All current residents were assessed for proper positioning while in bed to ensure safe and proper positioning. There were no other residents that required a bed	4/9/25

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F 558	Continued From page 3 On 03/19/2015 at 09:26 AM, the surveyor observed the resident in bed with NJ Exec Order 26.4b1 and the NJ Exec Order 26.4b1 . The surveyor reviewed the medical record for Resident #311. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: NJ Exec Order 26.4b1 . A review of the resident's comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Exec Order 26.4b1 included the resident had a Brief Interview for Mental Status (BIMS) score of NJ E out of 15, which indicated the resident's NJ Exec Order 26.4b1 was NJ Exec Order 26.4b1 . During an interview with the surveyor on 03/19/2025 at 12:09 PM, Certified Nursing Assistant (CNA #1) stated that part of their role is to ensure patient safety in the room. When asked how they would know if a patient is NJ Exec Order 26.4b1 in bed, CNA #1 stated that they would look for NJ Exec Order 26.4b1 like being NJ Exec Order 26.4b1 During an interview with the surveyor on 03/20/2025 at 10:17 AM, Licensed Nurse Practitioner (LPN #1) explained that residents are always monitored for NJ Exec Order 26.4 and that residents NJ Exec Order 26.4b1 . When asked what the procedure would be for those that NJ Exec Order 26.4b1 LPN #1 stated that they would be NJ Exec Order 26.4b1 and if that did not work all the beds in the facility can be NJ Exec Order 26.4b1 LPN #1 confirmed that nursing would contact maintenance to have	F 558	extender. Element Three- Systematic Change Nursing, therapy, and maintenance staff were re-in-serviced by the staff educator on the importance of timely accommodation and proper use of adaptive equipment to ensure resident needs are met. Staff were re-in-serviced by the staff educator on the importance of reporting the need for adaptive equipment in the maintenance work order log and the importance of follow through to ensure the resident's needs are being met timely and safely. Element Four-QAPI Resident bed positioning audits will be completed by the Director of Nursing or designee weekly for four weeks then monthly for two months. A current list of extenders will be maintained on the "end of day report". If there are any missing bed extenders or if it has been determined that a resident requires one, a bed extender will be immediately place on the bed. A monthly report will be submitted to the Administrator and the QAA committee for review for three months. The Maintenance Director will review the Maintenance work order log weekly for four weeks, then monthly for two months to ensure timely completion of all requests. Findings will be reported to the Administrator following each audit and at the QAA Committee meetings for 3 months for review and action.	

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F 558	Continued From page 4 the NJ Exec Order 26.4b1 because it would require an additional cushion to be added to the bed. On the same date and time, the surveyor entered Room NJ Exec [redacted] where Resident #311 was seated in the wheelchair next to the bed. Resident #311 stated that they were NJ Exec Order 26.4b1 [redacted] The surveyor showed a picture depicting Resident # 311 NJ Exec Order 26.4b1 [redacted] LPN #1 confirmed that this should have been completed to meet Resident #311 needs and prevent any NJ Exec Order 26.4b1. During an interview with the surveyor on 03/21/2025 at 10:21 AM, Registered Nurse Unit Manager (RNUM#1) confirmed that it was the nursing staff's responsibility to ensure that resident's NJ Ex Order 26.4b1 in bed. During an interview with the surveyors on 03/24/2025 at 10:11 AM, the US FOIA (b)(6) [redacted], in the presence of the US FOIA (b)(6) [redacted], confirmed that the nursing department should have contacted maintenance upon recognition that the resident's NJ Exec Order 26.4b1 [redacted]. A review the facility's undated "Resident Rights" document, included that resident's are " to live in safe, clean, comfortable and home-like environment. To be treated with courtesy, dignity, and respect [...]". The facility was unable to provide any policies regarding resident Accommodation of Needs. NJAC 8:39-4.1(a)11	F 558		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment	F 584		4/9/25

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F 584	Continued From page 5 CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and	F 584		

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F 584	Continued From page 6 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and pertinent facility documentation, it was determined that the facility failed to maintain a homelike environment that was clean, safe, and sanitary. This deficient practice was identified for 2 of 2 units (A Unit and B Unit). This deficient practice was evidenced by the following: On 03/19/2025 at 09:30 AM, Surveyor #1 observed the pantry area of A Unit. There was black debris on the floor near the refrigerator, and the microwave had brown debris inside and chipped paint. On 03/19/2025 at 10:14 AM, Surveyor #1 observed the pantry area of B Unit. A cabinet drawer near the refrigerator was missing, another drawer near the sink was off track, and a plunger along with a white rack was stored under the counter in plain sight. Additionally, the microwave contained brown debris. During an interview with Surveyor #1 on 03/21/2025 at 10:21 AM, the Registered Nurse/Unit Manager #1 (RN/UM #1) said that all facility staff are responsible for maintaining cleanliness on the units and throughout the facility. The staff should inform Environmental Services if any issues arise that are beyond their control. If staff notice broken furniture or equipment, they should document it in the maintenance log at the nurses' station so that	F 584	Element One- Corrective Actions * The pantry area of A wing that had the black debris on the floor near the refrigerator was cleaned and the microwave was removed from the area. * The cabinet drawer was replaced, and the other drawer was placed back on track, the plunger was moved to the janitor's closet, and the microwave was removed from use. * The crack on the floor of the A- wing shower and the two holes in the drywall were both repaired immediately. Element Two-Identification of at Risk Residents * All residents had the potential to be affected by the practice. Element Three- Systematic Changes * Staff were in-serviced by the staff educator on the importance of reporting needed maintenance repairs or environmental cleanliness concerns immediately for timely follow-up. Maintenance has a work order log binder on each unit that indicates needed repairs or work order requests. The log is checked daily and a completion date is noted when the required repair has been completed.	

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F 584	Continued From page 7 maintenance can address the repairs or replacements. On 03/21/2025 at 10:33 AM, while reviewing the maintenance logs with RN/UM #1, it was noted that there was no documentation regarding a missing cabinet drawer near the refrigerator or a drawer near the sink that was off track on the B Unit. During an interview with the [redacted] on 03/21/2025 at 11:45 AM, the [redacted] said that he walks around the building daily to check for issues and conducts rounds every Sunday to ensure that all tasks are completed, and everything is functioning properly. Maintenance logs are reviewed daily, and repairs are prioritized based on the availability of supplies and the severity of the issues. Typically, building repairs are finished within a week. A review of a facility undated policy titled, "Resident Rights", revealed under physical and personal environment, "To live in a safe, clean, comfortable, and home-like environment". N.J.A.C. 8:39-31.3(a) On 3/18/25 at 10:00 AM, Surveyor #2 observed the Central Shower Room on A wing. In the shower on the left side of the shower room, the surveyor observed a crack in the floor of the shower. On the wall to the right of the door, the surveyor observed 2 holes in the drywall.	F 584	Element Four-QAPI * To maintain and monitor on-going compliance the Maintenance Director and Environmental Service Directors or their designees will audit the pantry areas and showers two times a week for four weeks and then monthly for two months. Results of the audits will be provided to the Administrator and submitted to the QAA meetings to ensure on-going compliance.	

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F 584	Continued From page 8	F 584		

During an interview with the surveyors on 03/21/2025 at 11:45 AM, the US FOIA (b)(6) [redacted] stated that they round the building constantly monitoring the general conditions. When shown pictures of the crack in the flooring in the Central Shower Room and the hole in the drywall, the [redacted] confirmed that he is trying to figure out how to repair it.

During an interview with the surveyors on 03/24/2025 at 10:11 AM, the US FOIA (b)(6) [redacted], confirmed that the crack in the shower room floor and the hole in the drywall will be repaired.

A review the facility's undated "Resident Rights" document, included that resident's are " to live in safe, clean, comfortable and home-like environment. To be treated with courtesy, dignity, and respect [...]".

During the initial tour of the facility on 03/18/2025 at 10:04 AM, surveyor #3 entered Room [redacted] and observed Resident #311 in bed, who requested to have the NJ Exec Order 26.4b1 [redacted]. The surveyor opened the sliding window and observed that the outside screen was ripped. Resident #311 stated that they [redacted] having the NJ Exec Order 26.4b1 [redacted]. Surveyor #3 also observed that the wall across from Resident #311's bed had marking and gouges in the wall that chipped away the paint.

During an interview with the surveyors on 03/21/2025 at 11:45 AM, the US FOIA (b)(6) [redacted]

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F 584	Continued From page 9 US FOIA (b)(6)) stated that they round the building constantly monitoring the general conditions. When shown pictures of Resident #311 screen and wall, the US FOIA (b)(6) confirmed that the screen should not be torn and that the wall should not present in that fashion. During an interview with the surveyors on 03/24/2025 at 10:11 AM, the US FOIA (b)(6) [redacted], confirmed that the screen has been replaced. A review the facility's undated "Resident Rights" document, included that resident's are " to live in safe, clean, comfortable and home-like environment. To be treated with courtesy, dignity, and respect [...]". N.J.A.C. 8:39-31.4(a)	F 584		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Complaint # NJ 180316 Based on interview, review of the medical record, and review of other facility documentation, it was	F 689	Element One- Corrective Actions * Resident #12 NJ Exec Order the secured unit and NJ Exec Order 26.4b1 [redacted]	4/9/25

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F 689	Continued From page 10 determined that the facility failed to provide adequate NJ Exec Order 26.4b1 for a NJ Exec Order 26.4b1 resident with a known history of NJ Exec Order 26.4b1 which resulted in the resident NJ Exec Order 26 on NJ Exec Order 26.4b1. The deficient practice was identified for 1 of 2 residents reviewed for NJ Exec Order 26.4b1 (Resident #12). Resident #12, who was NJ Exec Order 26.4b1 with a known history of NJ Exec Order 26.4b1 from the facility on NJ Exec Order 26.4b1. The staff reported last seeing Resident #12 in their room at 6:15 AM on NJ Exec Order 26.4b1. The resident wore a NJ Exec Order 26.4b1) to their NJ Exec Order 26.4b1 that the physician ordered to be checked for placement and function every shift, and was last checked during the night shift on NJ Exec Order 26.4b1. On NJ Exec Order 26.4b1 at 6:39 AM, the NJ Exec Order 26.4b1 called the facility to report that Resident #12 was NJ Exec Order 26.4b1 the facility's NJ Exec Order 26.4b1 at an adjacent NJ Exec Order 26.4b1. Resident #12 was returned to the facility by the Emergency Medical Technicians (EMT) at approximately 7:15 AM. At that time, a NJ Exec Order 26.4b of Resident #12 was completed and NJ Exec Order 26.4b1 were noted. The facility's failure to provide adequate supervision to a NJ Exec Order 26.4b1 resident who was at risk for NJ Exec Order 26.4b1 and NJ Exec Order 26 posed a likelihood of serious harm, injury, impairment, or death. This resulted in an Immediate Jeopardy (IJ) situation. The IJ began on NJ Exec Order 26.4b1 at 6:15 AM, when Resident #12 NJ Exec Order 26.4b1. The facility's Administration was notified of the IJ on 3/20/2025 at 3:15 PM. The facility submitted an acceptable Removal Plan (RP) on 3/21/2025. The survey	F 689	NJ Exec Orde facility. NJ Exec was NJ Exec Order 26.4b1 in NJ Exec room at approximately 6:15 am. Resident #12 NJ Exec Order 26.4b1 to the facility NJ Exec Order 26.4b1 * Resident #12 was wearing a NJ Exec Order 26 at the time NJ Exec Order 26.4b1 the facility. Upon NJ Exec Order 26.4b1 to the facility NJ Exec Order 26.4b1 was checked, and it was still properly functioning. A NJ Exec was completed, and NJ Exe. The resident did not NJ Exec Order 26.4b1 upon NJ Exec NJ Exec Order 2 The care plan was reviewed and updated as appropriate to NJ Exec Order 26.4b1 Staff that care for Resident#12 received immediate re-education about conducting more NJ Exec Order 26.4b1 and reporting any NJ Exec Order 26.4b1 to the nurse immediately. *The Maintenance Director conducted a facility wide audit on March 30, 2025 of all doors to ensure the NJ Exec Order 26.4b1 system was properly functioning while waiting for the vendor to complete a full system review. *Audits were completed on March 20, 2025 for all residents at risk for elopement to ensure wander guard bracelets were properly working. * On March 20, 2025 , elopement binders were reviewed and all were accurate and up to date. * On March 20, 2025, elopement drills were completed on all shifts. *On March 20, 2025 the facility held a ad hoc QA meeting to review F689-J. Element Two- Identification of at Risk Residents	

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	315508	A. BUILDING _____ B. WING _____	C 03/24/2025

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F 689	Continued From page 11 team verified the implementation of the RP during the continuation of the on-site survey on 3/21/2025. The evidence is as follows: A review of the facility's policy titled, "Elopement of Resident" revised on 5/1/2024, revealed under "Policy" that; "Resident will be evaluated for elopement risk upon admission, re-admission, quarterly and with a change in condition as part of the nursing assessment process. Those determined to be at risk will receive appropriate interventions to reduce risk and minimize injury." A review of the electronic Medical Record (EMR) on 3/19/2025 at 11:55 AM, revealed the following: According to the Admission Record face sheet (an admission summary), Resident #12 was admitted with diagnoses including but not limited to; NJ Exec Order 26.4b1 [redacted] A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b1 revealed Resident #12 had a Brief Interview for Mental Status (BIMS) score of [redacted]/15 which indicated that Resident #12's [redacted] was NJ Exec Order 26.4b1. A further review of the MDS indicated the resident NJ Exec Order 26.4b1 [redacted] and used a NJ Exec Order 26.4b1 [redacted]. A review of Resident #12's individualized comprehensive care plan (ICCP) initiated on	F 689	* All residents that have been assessed to be at risk for elopement have the potential to be affected. Element Three- Systematic Changes * Facility staff received re-education about the wander guard system and checking resident with wander guard bracelets for function and observing their whereabouts frequently. * The vendor inspected the wander guard system to ensure it was functioning properly. * The US FOIA (b)(6) [redacted] completed in-service and competencies on March 20, 2025 for staff regarding elopements. This was also completed over the phone and via email. Any staff who were not in-serviced, received the in-service prior to the start of their shift. * All new staff upon hire receive education about resident safety including the function of the wander guard system and observations of residents who exhibit exit seeking behaviors. Element Four-QAPI * A root cause analysis and investigation of the elopement was immediately conducted to identify the root cause(s) of the elopement with corrective actions implemented as noted above to prevent future elopements. * The Maintenance Director or designee will conduct daily checks of all exit doors, Current Technologies Electrics will	

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F 689	Continued From page 12 NJ Exec Order 26.4b1, identified the resident as at risk for NJ Exec Order 26.4b1 and was revised on NJ Exec Order 26.4b1, for an NJ Exec Order 26.4b1. Interventions included; the resident NJ Exec Order 26.4b1 the facility without an NJ Exec Order 2 initiated on NJ Exec Order 26.4b1, utilize and monitor NJ Exec Order 26.4b1 per protocol initiated on NJ Exec Order 26.4b1, and utilize NJ Exec Order 26.4b1 technique as appropriate to NJ Exec Order 26.4 the resident if he/she nears exits or doorways. A review of the Order Summary Report revealed a physician's order dated NJ Exec Order 26.4b1, for a NJ Exec Order 26.4b1 placed on the resident's NJ Exec O [redacted] (update order with new date when NJ Exec Order 26.4 is changed); every shift to check for placement. A review of the Treatment Administration Record (TAR) dated NJ Exec Order 26.4b1 revealed the physician's order for the NJ Exec Order 26.4b1 was signed as having been checked for NJ Exec Order 26.4b1 and NJ Exec Order 26.4 on NJ Exec Order 26.4b1, during the 11:00 PM and 7:00 AM shift. A review of an NJ Exec Order 26.4b1 Evaluation dated NJ Exec Order 26.4b1, revealed that a NJ Exec Order 26.4b1 device was needed and NJ Exec Order 26 on NJ Exec Order 26.4b1 to the NJ Exec Order 26.4b1. A review of the Progress Notes (PN) dated NJ Exec Order 26.4b1 at 4:31 PM, revealed that the resident was NJ Exec Order 26.4b1 due to NJ Exec Order 26.4b1. The PN revealed that on the same date at 5:36 AM, the resident was observed NJ Exec Order 26.4b1 the unit asking for an NJ Exec and at one time NJ Exec Order 2 the NJ Exec Order 26.4b1 A PN dated NJ Exec Order 26.4b1 revealed that at 4:11 PM,	F 689	conduct quarterly inspections of the wander guard system doors to ensure proper functioning. The Maintenance Director will submit a monthly report to the QAA committee.	

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F 689	Continued From page 13 the NJ Exec Order 26.4b1 Nurse Practitioner documented that the resident was NJ Exec Order 26.4b1 and was NJ Exec Order 26.4b1 at that time. A PN dated NJ Exec Order 26.4b1, revealed that the resident had NJ Exec Order 26.4b1 ion, a NJ Exec Order 26.4b1 of an NJ Exec Order 26.4b1 drug, NJ Exec Order 26.4b1, and was not easily NJ Exec Order 26.4b1 A review of the facility's Investigation and Summary dated NJ Exec Order 26.4b1 revealed the following under the Resident's Pertinent Medical Information: the resident was NJ Exec Order 26.4b1 without an NJ Exec Order 26.4b1. The resident had a NJ Exec Order 26.4b1 on their NJ Exec Orde for NJ Exec Order 26.4b1 Under the "Description of the event" on NJ Exec Order 26.4b1, included the following: The facility staff last reported seeing Resident #12 in their room at 6:15 AM. At 6:39 AM, the NJ Exec Order 26.4b1 department received a call that an individual NJ Exec Order 26.4b1 by staff from an NJ Exec Order 26.4b1 facility. At approximately 6:50 AM, the local NJ Exec Order called the facility to notify that Resident #12 NJ Exec Order 26.4b1. Resident #12 was returned to the facility by the EMTs at approximately 7:15 AM. At that time, according to the Investigation and Summary, Resident #12 was NJ Exec Order 26.4b1 when they NJ Exec Order the NJ Exec Order 26 The NJ Exec Order 26.4b1 was checked upon	F 689		

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F 689	Continued From page 14 return and was still [redacted]. Resident #12 was assessed and [redacted] were determined. At that time, staff checked all residents in the facility to be sure they were accounted for and [redacted] Resident #12 while the facility waited for the Electronic Service Company for the [redacted] system to arrive. The summary revealed that an audit was completed of all [redacted]. It was determined that the [redacted] system on the egress door from the secured unit into the main dining room was functioning intermittently. Staff were assigned to monitor the door until the doors could be assessed by the Electronic Service Company. The company was contacted immediately and came to assess the functionality of the doors. Repairs were made to ensure the doors were safely operating. A review of the facility's Investigation and Summary under Investigation Findings revealed that it was inconclusive how Resident #12 [redacted] the facility. A review of the Investigation and Summary under "Conclusion and Resolution" revealed that the care plan was reviewed and updated with additional interventions. The medical doctor and family were notified. The Department of Health and Long Term Care Ombudsman were notified. The Electronic Service Company conducted an assessment of all [redacted] and made repairs if needed to ensure all doors functioned properly. Daily maintenance checks of all [redacted] to be sure they functioned properly. Nursing staff checked the [redacted] daily to ensure function.	F 689		

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F 689	Continued From page 15 A review of an invoice dated [NJ Exec Order 26.4b1] from the Electronic Service Company revealed that a [NJ Exec Order 26.4b1] of all doors was done today due to an [NJ Exec Order 26.4b1]. The [NJ Exec Order 26.4b1] at the [NJ Exec Or] was not working. Door #[NJ Exe] which led to the service corridor was determined to be defective. The invoice revealed Door #[NJ Exec] which led to the parking lot and could be accessed from Door #[NJ Exe] was determined by the company to not be equipped for [NJ Exec Order 26.4b1]. The Electronic Service Company installed the [NJ Exec Order 26.4b1] control system at that time. The invoice revealed that Door #[NJ Exec] which was the entry/exit of the B-Unit, was determined to have a faulty magnetic lock. A review of a typed letter from the Electronic Service Company dated 11/22/2024, revealed: "Double doors service corridor 135DE panel found to be faulty. Replaced panel and tested good. Set loiter for 15 seconds. The loading dock was just access control, upgraded from 500 into 135DE as requested. Tested good. Set loiter for 15 seconds. B-Unit double doors entry/exit replaced faulty magnetic lock and tested good." A review of a handwritten statement signed by the Certified Nurse Aide (CNA #1) on duty [NJ Exec Order 26.4b1], revealed the following: "Resident was [NJ Exec Order 26.4b1] but was noticed [the resident] was [NJ Exec Order 26.4b1] 6:45 AM check on [the resident] at 6:15 AM, resident was sitting in room in bed. I was notified by nurse at 6:40 AM." A review of a handwritten statement signed by the Licensed Practical Nurse (LPN #1) on duty on [NJ Exec Order 26.4b1] revealed the following: "I was told by the nurse that [NJ Exec Order] called [NJ Exec Order 26] reporting that	F 689		

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F 689	Continued From page 16 they had [Resident #12] NJ Exec Order 26.4b1. The NJ Exec [redacted] resident was around 5:45 AM while [the resident] was standing by the door to [the resident's] room as I was passing my [medications]. That was the NJ Exec Order 26.4b1 [redacted] I had to go to another hallway to give my [medications]." A review of a handwritten statement signed by CNA #2 on duty on NJ Exec Order 26.4b1, revealed the following: "The nurse told me that the resident NJ Exec Order 26.4b and is with the NJ Exec Order 2. The last time I was with the resident was around a little at 6 AM. Because after my rounds I went on a break to the NJ Exec Order 26.4b station." A review of a handwritten statement signed by LPN #2 on duty NJ Exec Order 26.4b1, revealed the following: "At 645 [AM], NJ Exec Order 2 nurse reported NJ Exec Order called to say NJ Exec Order 26.4b1 [Resident #12]. Went into room to see [the resident's] NJ Exec Order 26.4b1. I NJ Exec Order 26.4b1 Resident #12] sitting in [their] chair at approximately 5:30 AM in [the resident's] room. I was down the hall with another resident for [approximately] 20 minutes. NJ Exec Order 26.4b1 [redacted] During an interview with the surveyor on 3/20/2025 at 11:09 AM, the US FOIA (b)(6) [redacted] stated that the egress door (Door #NJ Exec [redacted] from the secure unit into the dining room worked intermittently. The US FOIA (b)(6) continued that the door used to be activated by a push button but was now an electronic numeric pad, and the system shut down upon the approach of a NJ Exec Order 26.4b1. The US FOIA (b)(6) stated that the door into the service area (Door #NJ Exec [redacted] that went towards the kitchen was worked on by the Electronic Service Company. The US FOIA (b)(6)	F 689		

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F 689	Continued From page 17	F 689		

stated that the camera located over the [NJ Exec Order 26.4] nurses station did not cover Door #[NJ Exe] and that the cameras worked intermittently as well. The [US FOIA (b)(6)] stated there was no camera footage that captured of Resident #12's [NJ Exec Order 26.4b1]

During an interview with the surveyor on 3/20/2025 at 12:06 PM, the [US FOIA (b)(6)] revealed the following information:

The [US FOIA] had been employed at the facility since [NJ Exec Ord] and stated that every Sunday, he checked the doors on A-Wing and B-Wing with a [NJ Exec Order 26.4b1] at each keypad to ensure it locked and beeped. The [US FOIA] stated that meant that it was locking and not allowing the doors to open. The [US FOIA] stated he then put the tag away went back to the lock and tested for a fifteen second push, for emergencies. Once the lock was released, he closed the door, cleared the [NJ Exec Order] and marked that it was checked. The [US FOIA] stated that every single door that had a keypad was included in the checks. When asked by the surveyor if he was aware that Door #[NJ Exe] functioned intermittently prior to the [NJ Exec Order 26.4b1] the [US FOIA] replied, "Yes, I did." When asked by the surveyor if he was aware that Door #[NJ Exe] was defective prior to the [NJ Exec Order 26.4b1] the [US FOIA] replied, "That thing never worked since I've worked here. The only thing I can say is probably a mistake of human."

An acceptable RP was received on 3/21/2025 at 10:48 AM, which indicated the action the facility took to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice including; Resident #12's [NJ Exec O] was assessed

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F 689	Continued From page 18 NJ Exec Order 26.4b1 [redacted] Resident #12 was seen by NJ Exec Order 26.4b1 services within twenty-four hours without medication modifications and their plan of care was updated after Interdisciplinary Team review, the exit door on the unit was monitored by rotating staff pending vendor arrival, the US FOIA conducted a house wide audit of all doors to ensure the NJ Exec Order 26.4b1 was functioning, the US FOIA (b)(6))/designee performed a house wide audit of all residents at risk for NJ Exec Order 26.4b1 to ensure appropriate monitoring was in place, the US FOIA (b) and US FOIA (b) completed education and initiated competencies on facility's "Elopement Policy." The survey team verified the implementation of the RP during the continuation of the on-site survey on 3/21/2025.	F 689		
F 755 SS=D	NJAC 8:39-27.1(a) Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures	F 755		4/9/25

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F 755	Continued From page 19 that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent documentation, it was determined that the facility failed to establish a system of records for all controlled drugs in sufficient detail to enable an accurate reconciliation for the dispensing of controlled medications for 1 out of 3 medication carts inspected for the Medication Storage and Labeling task. This deficient practice was evidenced by the following: On 03/18/2025 at 10:31 AM, in the presence of the Licensed Practical Nurse (LPN)# 1, the surveyor inspected the medication cart on A wing labeled cart one for storage and labeling of	F 755	Element One-Corrective Actions * A reconciliation of the narcotic inventory was immediately conducted on March 18, 2025 to ensure there were no discrepancies in the medication counts. There were no discrepancies found as a result of the audit. * The LPN #1 was immediately re-educated and counseled on March 18, 2025 by the Director of Nursing on proper controlled drugs administration and documentation. Element Two-Identification of at Risk Residents	

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F 755	Continued From page 20 medications. During reconciliation of controlled medications, the surveyor observed 7 Lyrica (a medication used to treat pain due to nerve damage) 75mg (milligram) in the blister pack in the narcotic box, but the Controlled Drug Sheet (CDS) documented 8 were left. The surveyor also observed 18 Oxycodone HCL Oxycontin (a narcotic medication used to treat pain)15 mg in the blister pack in the narcotic box, but the CDS documented 19 were left. Lastly the surveyor observed 37 Tramadol (a medication used to treat pain) 50mg in the blister pack in the narcotic box, but the CDS documented 38 were left. LPN #1 stated "I did sign them out on the computer". When asked if the meds should have been signed out on the CDS, the LPN #1 replied, "yes". During an interview on 03/19/2025 at 01:09 PM with the surveyor, the US FOIA (b)(6) said that narcotics should be signed out in the CDS when they are administered to show that the medications were administered or destroyed. Review of the facility's policy titled "Controlled Drugs: Management of" revealed under, "Policy" that "The management of controlled drugs - including the ordering, receipt, storage, administration, ongoing inventory, and destruction is conducted under the direction and ultimate responsibility of the Center Executive Director and Center Nurse Executive and follows safe practice and federal/regulations." NJAC 8:39-29.7(c)	F 755	* All residents who receive narcotics/ controlled drugs have the potential to be affected by the practice. Element Three-Systematic Changes * The Controlled Drug policy was revised to mandate documentation on controlled drug sheets immediately after administration. A double signature protocol was implemented for shift to shift handoff. * Nursing staff were re-educated by the Director of Nursing and staff educator on the controlled drug policy and the importance of signing out narcotics in the resident's electronic medical record as well as, on the "Controlled Drug Sheet" at the time of the administration. * Nursing staff receive education regarding proper documentation of controlled drug administration at time of hire and during annual in-service education. Element Four-QAPI * Director of Nursing or designee will conduct random controlled drug sheet audits two times a week for four weeks, then weekly for one month. Any deviations from the controlled drug policy will be immediately addressed with the employee and education and appropriate counseling will be initiated. The Director of Nursing or designee will present the findings of the audits monthly for 2 months to the Administrator and the QAA committee.	

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	315508	A. BUILDING _____ B. WING _____	C 03/24/2025

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**

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F 761	Continued From page 21	F 761		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents it was determined that the facility failed to a) ensure all medical supplies were stored in accordance with professional standards by having expired supplies, and b) keep medications labeled properly specifically by not labeling medications with an opened date. The deficient practice was identified in 1 of 1 medication storage rooms	F 761	Element One- Corrective Actions * The seven expired culture and sensitivity transfer straw kits were immediately discarded on March 18, 2025. * The undated vials were discarded immediately on March 18, 2025 according to the facility policy and manufacturer	4/9/25

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F 761	Continued From page 22 inspected and 2 of 3 medication carts reviewed under the Medication Task. The deficient practice was evidenced by the following: a) On 03/18/2025 at 10:01 AM while on Unit B, the surveyor inspected the medication room. At that time 7 culture and sensitivity transfer straw kits were observed with the expiration date of 10/23. At the that time the surveyor interviewed the US FOIA (b)(6) said she doesn't think the center uses the kits anymore. When asked if there should be anything expired in the medication room, the US FOIA replied, "no there shouldn't be anything expired." b) On 03/18/25 at 10:23 AM while on Unit A, the surveyor inspected medication cart #2. In the top drawer of the cart, the surveyor observed an opened insulin (a medication to help control blood sugar) multi-dose vial without a date it was opened. In the same drawer the surveyor observed a heparin (a medication that prevents blood clots) multi-dose vial without a date it was opened. At that time of the inspection, the surveyor interviewed Licensed Practical Nurse (LPN) # 1. LPN # 1 said that she thinks the medications came in during the last shift and were open for the 6 am medication pass. LPN # 1 also said that when the medications were opened, they should have been dated. On 03/18/25 at 10:31 AM while on Unit A the surveyor inspected medication cart #1. In the top drawer of the cart, the surveyor observed 2 opened insulin multi-dose vials without a date	F 761	guidelines. Element Two- Identification of at Risk Residents All residents have the potential to be affected by the practice. Element Three- Systematic Changes *Nursing staff were re-educated by the Director of Nursing and the staff educator on the proper monitoring of expiration dates and disposal procedures. * A monthly supply check log was implemented and placed in each medication room. Unit managers were re-educated for them or their designee to conduct weekly checks for expiration dates and remove any expired products per policy. * The pharmacy was immediately contacted to report the error in sending multi-dose vials of heparin and insulin. Nursing staff were in-serviced by the Director of Nursing and the staff educator to immediately report a delivery that includes multi-dose items for these medications. Nursing staff were also educated by the Director of Nursing and the staff educator on labeling requirements and safe medication practices. Element Four- Quality Assurance * The Director of Nursing or designee will perform medication cart and refrigerator audits three times a week for four weeks	

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F 761	Continued From page 23 they were opened. At the time of inspection, the survey interviewed LPN #2. LPN #2 said "they should have open dates on them." During an interview on 03/19/2025 at 01:09 PM with the surveyor, the US FOIA (b)(6) said there should not be anything expired in the medication's rooms. The US FOIA (b) also said the multi-use vials should be labeled when they are opened. A review of a facility provided policy with a review date of 3/1/2025 and titled. "Medication Storage Policy" revealed under, "Policy Statement" that, "All medications must be stored securely, maintained at appropriate temperatures, and managed to prevent contamination, diversion and improper use." The policy also revealed under, "1. General Medication Storage Requirements:" that, "multi-dose vials and liquid medications must be labeled with the date of opening and used within the manufacturer's recommended timeframe." N.J.A.C. § 8:39-29.4 (a) (g)	F 761	and then monthly for two months. Non-compliance will result in immediate education and possible counseling. A monthly report of the audits will be submitted to the QAA committee for review for 3 months.	
F 814 SS=D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and pertinent facility documentation, it was determined that the facility failed to properly dispose of garbage and refuse. This deficient practice was identified outside on the facility's property.	F 814	Element One-Corrective Actions * The facility conducts a facility wide clean up two times a year, in addition to regularly scheduled environmental	4/9/25

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F 814	Continued From page 24 This deficient practice was evidenced by the following: On 03/18/2025 at 10:21 AM, the surveyor observed a garage in the facility's parking lot, where there were several items, including, but not limited to, a cart for oxygen tanks filled with empty portable tanks, a large oxygen tank, wooden pallets, a toilet, and a wheelchair. On 03/18/2025 at 10:22 AM, the surveyor observed several items near the trash can and garbage compactor outside of the facility, including, but not limited to, a folded mattress, a television, tires, crates, and chairs. On 03/18/2025 at 10:23 AM, the surveyor observed several items behind the facility, in the parking lot near a storage bin. These items included, but were not limited to, a shower bed with foam cushioning, a shower chair, trash can lids, a bed frame with a mattress, a pile of leaves, wooden flat pallets, a whirlpool tub with bags of debris, and various gardening supplies. During an interview with the US FOIA (b)(6) on 03/21/2025 at 11:45 AM, the US FOIA said that the maintenance team handles garbage and bulk waste outside of the facility. Oxygen tanks are stored outside once empty, and maintenance contacts the oxygen company to pick them up once the cart is full. Gardening supplies are also kept outside due to a lack of storage space. The Township does not permit bulk trash in regular bins, so the facility must arrange for a container to take the trash to the dumpster. The facility was unable to provide a policy	F 814	rounds. A policy was developed to address the proper disposal of garbage and refuse in accordance with township bulk disposal requirements. * The empty oxygen tanks and the large empty oxygen tank were immediately picked up by the oxygen supply company and a schedule for pickups reviewed with a secure location identified to store empty tanks until the pick up date. * Gardening supplies were removed and stored in an appropriate location. * A dumpster was requested on 3/14/25 and delivered on 3/18/25. The removal of discarded items were disposed of on 3/18/25 and completed on 3/21/25. All items identified by the surveyor were properly discarded including: wood pallets, a toilet, a wheelchair, a folder mattress, a television, tires, crates, chairs, a shower bed with foam cushioning, a shower chair, trashcan lids, bed frame, flat pallets, and a whirlpool tub. Element Two- Identification of at Risk Residents. * All residents have the potential to be affected by the practice. Element Three- Systematic Change * Dietary, Environmental Services, and Maintenance staff were in-serviced by the Administrator on maintaining the trash area free of trash and miscellaneous items that do not fit in the garbage compactor. * The US FOIA (b)(6) was	

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F 814	Continued From page 25 regarding proper dispose of garbage and refuse. NJAC 8:39-19.7	F 814	re-educated by the Administrator about the need to request more frequent bulk pickup if needed and to ensure a dumpster has been delviered prior to removing the items from the facility. This will ensure miscellaneous items are properly stored and disposed of timely. Element Four- QAPI * The Administrator, Maintenance Director, Housekeeping Director, and Dietary Director will make rounds outside the facility to ensure all bulk material and trash are properly disposed of three times a week for 4 weeks, then weekly for 2 months and then on-going to ensure monitoring and compliance. Administrator will submit a report o the QAA monthly to ensure monitoring and compliance.	

New Jersey Department of Health

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S 000	Initial Comments Complaint #: NJ00174178, NJ00180316 The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint # NJ00180316, NJ00174178 Based on interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Findings include: A.) Reference: New Jersey Department of Health	S 560	Element One- Corrective Actions *No individual residents were affected by the practice as all residents received care timely. * A staffing analysis was completed by shift to determine the minimum amount of direct care staff and licensed nursing staff required by regulatory requirements to meet the care needs of the residents based on the daily census. The staffing schedule was reviewed by the DON with the staffing coordinator to identify by shift	4/9/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/12/25

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S 560	Continued From page 1 (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. For the week of Complaint staffing from 05/26/2024 to 06/01/2024, the facility was deficient in CNA staffing for residents on 4 of 7 day shifts as follows: -05/26/24 had 11 CNAs for 101 residents on the day shift, required at least 13 CNAs. -05/28/24 had 10 CNAs for 99 residents on the day shift, required at least 12 CNAs. -05/31/24 had 9 CNAs for 98 residents on the day shift, required at least 12 CNAs. -06/01/24 had 10 CNAs for 97 residents on the day shift, required at least 12 CNAs. 2. For the week of Complaint staffing from	S 560	the required numbers of staff. *Agencies were contacted to fill vacant direct care certified nurse aide and licensed nurse positions while the facility advertised for more staff. As a result, the facility has been able to overstaff with direct care staff some days of the week. *When there are additional direct care staff these individals are assigned to provide residents with additional bathing, grooming, and hygiene. The additional staff are also assigned to organizing resident rooms, clean high touch surfaces in resident rooms and spend time meeting the psychosocial needs of the residents. * Assignments were reviewed to assure residents requiring total assistance were not all on one assignment. * Job applications are readiliy availble at the reception desk to ensure individals looking for a job can be provided with an application immediately and an interview can be coordinated. Element Two- Identification of at Risk Residents *All residents have the potential to be affected by this practice. Element Three-Systematic Changes * Administration has formed a staffing committee and has conducted salary analyses and implemented creative strategies for attracting new employees to minimize the use of agency personnel. * Bonuses and incentive programs were previously implemented to attract and to retain current staff.	

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S 560	Continued From page 2 11/17/2024 to 11/23/2024, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts as follows: -11/17/24 had 11 CNAs for 111 residents on the day shift, required at least 14 CNAs. -11/18/24 had 11 CNAs for 111 residents on the day shift, required at least 14 CNAs. -11/19/24 had 12 CNAs for 111 residents on the day shift, required at least 14 CNAs. -11/20/24 had 11 CNAs for 110 residents on the day shift, required at least 14 CNAs. -11/23/24 had 10 CNAs for 110 residents on the day shift, required at least 14 CNAs. 3. For the 2 weeks of staffing prior to survey from 03/02/2024 to 03/15/2024, the facility was deficient in CNA staffing for residents on 5 of 14 day shifts as follows: -03/02/25 had 11 CNAs for 115 residents on the day shift, required at least 14 CNAs. -03/03/25 had 9 CNAs for 115 residents on the day shift, required at least 14 CNAs. -03/08/25 had 12 CNAs for 113 residents on the day shift, required at least 14 CNAs. -03/09/25 had 10 CNAs for 113 residents on the day shift, required at least 14 CNAs. -03/14/25 had 11 CNAs for 114 residents on the day shift, required at least 14 CNAs. During an interview on 03/20/25 at 12:22 PM, with the surveyor, the staffing coordinator stated that she is aware of the minimum direct care staffing requirement. When asked if the facility is meeting the requirement she responded that she does her best and that the facility used agencies to meet the requirements.	S 560	* Referral bonuses were implemented for current employees which supports filling vacant position as well as, retaining current staff. * An employee recognition committee comprised of front-line workers was implemented to plan events to improve the moral of staff and recognize the exemplary services provided by staff. *Quarterly employee appreciation events are planned by the committee to improve retention and attract new employees. *Improvements in the environment and working conditions have helped attract new staff. * The facility utilizes all types of digital media as well as recruiters to identify and hire new staff as appropriate. * The facility management team is working with the union to promote cooperation and minimize call outs. Element Four- Quality Assurance * Daily staffing levels are reported to the management team and management company and additional incentives are provided for working an extra shift if needed. The success of the bonuses and incentives is analyzed by the facility Administrator and the Director of Nursing who make recommendations at the weekly meetings and to the company regarding what incentives or bonuses are working. * Staffing is discussed at daily morning operation meetings and recommendations solicited from the management team about ways to attract new hires to fill vacant positions.	

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S 560	Continued From page 3 A review of the undated provided policy titled, "Staffing Protocol", reflected 2. Certified Nursing Assistants are available each shift to provide the care and services needed of each resident as outlined on the resident's comprehensive care plan.	S 560	*Staffing levels of direct care staff and recruitment efforts are discussed daily by nursing management and the Administrator, are reported monthly to the company, and are reviewed at the quarterly QAPI meetings. *Vacancy rates are reviewed weekly by the Director of Nursing and discussed with the Administrator. The effectiveness of strategies to attract and retain staff are discussed and strategies modified as needed. Findings are also discussed monthly with the company that provides direct assistance with recruitment efforts.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315508 Y1	A. Building B. Wing Y2	5/9/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN POINTE POST ACUTE NURSING & REHABILITATION	3809 BAYSHORE ROAD NORTH CAPE MAY, NJ 08204

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0689 Reg. # 483.25(d)(1)(2) LSC	Correction Completed 04/09/2025	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
3/24/2025	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0558	Correction	ID Prefix F0584	Correction	ID Prefix F0689	Correction
Reg. # 483.10(e)(3)	Completed	Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.25(d)(1)(2)	Completed
LSC	04/09/2025	LSC	04/09/2025	LSC	04/09/2025
ID Prefix F0755	Correction	ID Prefix F0761	Correction	ID Prefix F0814	Correction
Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.60(i)(4)	Completed
LSC	04/09/2025	LSC	04/09/2025	LSC	04/09/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
3/24/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
05001 Y1	A. Building B. Wing Y2	5/9/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN POINTE POST ACUTE NURSING & REHABILITATION	3809 BAYSHORE ROAD NORTH CAPE MAY, NJ 08204

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 04/09/2025	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 3/24/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

 EVENT ID: XZTC12

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
05001 Y1	A. Building B. Wing Y2	5/9/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN POINTE POST ACUTE NURSING & REHABILITATION	3809 BAYSHORE ROAD NORTH CAPE MAY, NJ 08204

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 04/09/2025	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
3/24/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

 EVENT ID: XZTC12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315508	A. BUILDING **01** B. WING _____	**03/24/2025**

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**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An Emergency Preparedness Survey was conducted by the New Jersey Department of Health on 3/18/25 and 3/19/25, the facility is NOT in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
E 026 SS=F	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) §403.748(b)(8), §416.54(b)(6), §418.113(b)(6)(C)(iv), §441.184(b)(8), §460.84(b)(9), §482.15(b)(8), §483.73(b)(8), §483.475(b)(8), §485.542(b)(7), §485.625(b)(8), §485.920(b)(7), §494.62(b)(7). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and	E 026		4/9/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/12/2025

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315508	A. BUILDING **01** B. WING _____	**03/24/2025**

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E 026	Continued From page 1 procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on a review of the Emergency Preparedness Manual (EPM) and interview on 3/19/25 in the presence of facility Administration, it was determined that the facility failed to include a policy and procedure for the facility's roles under an 1135 waiver as declared by the Secretary. This deficient practice had the potential to affect all residents and was evidenced by the following: A record review of the EPM between 1:05 PM and 3:04 PM revealed that the facility's EPM did not include a policy and procedure for the facility's role under a 1135 waiver as declared by the Secretary. In an interview at 3:37 PM, the facility's US FOIA (b)(6) confirmed the facility did not have a policy and procedure for the facility's role under an 1135 waiver and were not aware of the requirement. The facility's US FOIA (b)(6) were informed of the deficient practice at the Life Safety Code exit conference at 4:09 PM. N.J.A.C. 8:39-31.6	E 026	Element One- Corrective Actions *The facility incorporated a policy and procedure concerning the 1135 waiver as declared by the Secretary into the facility's Emergency Preparedness manual on April 9, 2025. The management team and staff as appropriate, received education by the Administrator and the staff educator regarding the 1135 waiver policy and procedure of their role if a waiver is declared. Element Two- Identification of at Risk Residents * All residents have the potential to be affected by the practice. Element Three- Systematic Changes * The management team and staff as appropriate , received education by the Administrator and staff educator regarding the 1135 waiver policy and procedure and their role if a waiver is declared. Element Four- QAPI * During the annual review of the facility's Emergency Preparedness manual, The Administrator will review the policy and	

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	315508	A. BUILDING **01** B. WING _____	**03/24/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 026	Continued From page 2	E 026	procedure regarding an 1135 waiver as declared by the Secretary will be reviewed to ensure that it is update and remains in the manual as required.	
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 3/18/25 and 3/19/25. Pelican Pointe was found not to be in compliance with requirements for participation in Medicare/Medicaid at 42 CFR 483.90 (A) Life Safety from fire and the 2012 edition of the National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), chapter 19 EXISTING health care occupancy. The facility is a one-story building constructed in 1985. The facility has concrete flooring, wood frame roofing and bearing walls and brick exterior. The facility is noted to be a type V (111) with complete sprinkler system and complete fire alarm system with smoke detection in all corridors and bedrooms. The facility has a 125 KW (kilowatt) diesel generator that operates at 75% of load when tested. The facility has 8 smoke zones. The facility has 120 licensed beds and had 115 occupied beds at survey. .	K 000		
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to	K 211		4/9/25

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	315508	A. BUILDING **01** B. WING _____	**03/24/2025**

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K 211	Continued From page 3 full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 3/19/25 in the presence of the US FOIA (b)(6) it was determined the facility failed to ensure means of egress were continuously maintained free of all obstructions to full use in case of an emergency in accordance with NFPA 101: 2012 Edition, Sections 19.2.1 and 7.1.10.1. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 9:53 AM of exit door #27 revealed the door did not open when the activated 15 second delayed egress hardware disengaged the magnetic lock. It was determined the door was stuck in the door frame and required excessive force to open the door. In an interview at the time, the US FOIA confirmed the observation and stated the door was rubbing on the door frame in 2 places that were identified by the US FOIA (b) The facility's US FOIA (b)(6) were informed of the deficient practice at the Life Safety Code exit conference at 4:09 PM. N.J.A.C. 8:39-31.2(e)	K 211	Element One- Corrective Actions * The exit door #27 doorframe was repaired and the 15 second delay egress function works correctly as required. * The Maintenance Director checked all other doors with 15 second delayed egress bars an confirmed they all worked properly. Element Two- Identification of at Risk Residents * All residents had the potential to be affected by the practice. Element Three-Systematic Changes *The US FOIA (b)(6) were re-educated to check delayed egress doors with delayed egress bars during environmental rounds to ensure they are in functional order. Element Four- QAPI * The Maintenance Director or designee will check the doors for proper functioning daily for four weeks then on-going monthly. If there are any malfunctions, they will be addressed immediately. The Maintenance Director will submit a report with findings monthly to the Administrator and the QAA committee for review.	

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K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and	K 222		4/9/25

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K 222	Continued From page 5 ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 3/19/25 in the presence of the[redacted], it was determined the facility failed to ensure: 1. doors in a required means of egress were not equipped with a latch or lock, and 2. doors equipped with delayed egress were provided with the required sign, in accordance with NFPA 101: 2012 Edition, Sections 7.2.1, 7.2.1.5.3, 7.2.1.9, 7.2.1.9.1.3, 7.2.1.6.1.1(4) and 19.2.2.2.1. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 10:31 AM revealed the main entrance/exit had a foyer with 2 sets of single leaf sliding doors that were each equipped with an operational thumb latch in the path of egress to	K 222	Element One- Corrective Actions * The Maintenance Director checked all exit doors with means of egress to allow egress as required. * The main entrance sliding doors thumb latch locks were removed to ensure the egress to exit the building. *A sign was placed on door #20 noting push till alarm sounds door can can be opened in 15 seconds. Element Two-Identification of at Risk Residents * All residents had the potential to be affected by the practice.	

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K 222	Continued From page 6 exit the building. Both doors had required instructional signs directing egress evacuation to push to open that would be prevented by thumb latch lock. An observation at 12:36 PM of corridor exterior exit door number 20 revealed the door was equipped with delayed egress hardware and had no sign stating "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS". In an interviews at the times, the [redacted] confirmed the observations. The facility's [redacted] were informed of the deficient practice at the Life Safety Code exit conference at 4:09 PM. N.J.A.C. 8:39-31.2(e)	K 222	Element Three- Systematic Changes * The two operational thumb latches were removed, one was on the outside door and one was on the inside door. No changes can be made to any doors without the approval of the Administrator. Element Four-QAPI * Administrator will not approve any thumb latches for the front door. The doors will be checked by the Maintenance Director or designee daily for four weeks, weekly for 1 month, and monthly thereafter, to ensure that no thumb latches are present. Findings will be reported to the Administrator and at the QAA meeting monthly for further action if needed.	
K 293 SS=F	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 3/19/25 in the presence of the [redacted], it was determined the facility failed to ensure an exit sign had directional indicators	K 293	Element One- Corrective Actions * The exit sign #35 that was located above the double smoke doors #26 was	4/9/25

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K 293	Continued From page 7 showing the correct direction of travel to the nearest exit in accordance with NFPA 101: 2012 Edition, Section 7.10, 7.10.1.2, 7.10.1.5, 7.10.2, and 7.10.6.2. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 10:31 AM of the exit sign number 35, above double smoke doors number 26 revealed, both the right and left [redacted] -type indicator arrows were open and illuminated indicating there was egress in both directions to an exit. Travel to the right led directly into a break room with no exit. In an interview at the time the [redacted] confirmed the observation. The facility's [redacted] were informed of the deficient practice at the Life Safety Code exit conference at 4:09 PM. N.J.A.C. 8:39-31.2(e)	K 293	replaced. It is now illuminating properly. Element Two- Identification of at Risk Residents * All residents have the potential to be affected by the practice. Element Three- Systematic Changes * The [redacted] were re-educated on exit doors and egress sign lighting to ensure they are operating properly. * The Maintenance Director or designee will conduct audits of all exit door lights during walking rounds for proper functioning to ensure correct illumination and accurate directional indicators. Any signs that are not working at full capacity will be replaced. Element Four-QAPI * The Maintenance Director or designee will conduct audits of all exit signs weekly for 4 weeks, then monthly thereafter, for proper functioning of all the exit signs to ensure accurate illumination and directional indictors. Any signs that are not properly functioning will be replaced timely. * The Maintenance Director will report monthly the findings of the audit to the Administrator and the QAA committee for review.	
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101	K 321		4/9/25

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K 321	Continued From page 8 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 3/19/25 in the presence of the US FOIA (b)(6)), it was determined the facility failed to ensure hazardous area doors were self closing or automatic closing in accordance with NFPA 101: 2012 Edition, Section 7.2.1.8. This deficient practice had the potential to affect 60 residents	K 321	Element One- Corrective Actions * The large storeroom double doors were adjusted by Maintenance so they properly latch into their frame. * The B wing soiled utility room had had a self closing lock installed.	

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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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 321	Continued From page 9 and was evidenced by the following: Observations during a facility tour between 9:30 AM and 1:00 PM revealed: 1. The large storage room by laundry had double doors that did not shut all the way into their frame and latch. The closer was impeding the proper operation of the mechanism and one door leaf was held open by the astragal of the other leaf. The room was greater than 50 square feet and stored combustible material. 2. The B-wing soiled utility room door was not equipped with a self-closing device. The room was greater than 50 square feet and contained combustible trash and soiled lined hampers. 3. The B-wing storage room by nurses station door was not equipped with a self-closing device. The room was greater than 50 square feet and contained combustible supply material storage. 4. The B-wing storage room (next to janitors closet) door did not positive latch and was a corridor and hazardous area door. There was medical tape over the door frame strike hole preventing it from latching. The room was greater than 50 square feet and contained combustible material storage. In interviews at the times, the [redacted] confirmed the observations. The facility's [redacted] were informed of the deficient practice at the Life Safety Code exit conference at 4:09 PM. N.J.A.C. 8:39-31.2(e)	K 321	* The B wing storage room by the nurse's station had a self closing latch installed. * The B wing storage room located next to the janitor's door had a self-closing latch installed. Element Two-Identification of at Risk Residents * All resdients have the potential to be affected by the practice. Element Three-Systematic Changes * Re-education was provided to the [redacted] regarding to ensure the use of self-closing doors and proper locking mechanisms on all doors identified as containing hazardous materials. *An audit of all doors was completed to ensure that all hazardous areas are protected with self-closing doors and automatic locks. Element Four- QAPI * The Maintenance Director or designee will audit the doors for properly functioning self-closing and self-locking mechanisms when required, weekly for four weeks, then monthly thereafter. The audit report will be submitted monthly nto the Administrator and the QAA committee for review.	

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K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview on 3/18/25 in the presence of the US FOIA (b)(6)), it was determined the facility failed to ensure cooking equipment was protected in accordance with NFPA 101: 2012 Edition, NFPA 17A: 2009 Edition and NFPA 96: 2011 Edition. This deficient practice had the potential to affect all residents and was evidenced by the following:	K 324	Element One- Corrective Actions * The fryer was immediately removed on December 26, 2024. * Harring Fire Protection conducted an inspection of the work on March 6, 2025. * The facility will adhere to the fire safety standards and correct any noted infractions by the local fire inspector in a	4/9/25

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K 324	Continued From page 11 A record review of the semiannual kitchen suppression reports for the last 12 months revealed the reports were marked as non-compliant. The kitchen suppression report dated 7/10/24 and marked as non-compliant noted a deficiency. The report stated under Description of deficiencies: "Fryer added to cook line since last inspection no nozzle coverage". A record review on the local fire quarterly inspection reports going back the last 12 months revealed there were no certificates of compliance issued and the inspection reports contained: Notice of Violation and Order to Correct for the kitchen. The notices of violation issued by the local fire bureau and dated 08/19/24 and 10/24/24 both stated under Description: "Cooking line has been altered - not all appliances are protected". In an interview at the time, the [redacted] stated that the facility had installed and used a deep fryer on the kitchen cooking line that was not protected by the fire suppression system. When the non-compliance was identified by the authorities, the facility removed the fryer. The facility's [redacted] were informed of the deficient practice at the Life Safety Code exit conference at 4:09 PM. N.J.A.C. 8:39-31.2(e), 5:70-3 NFPA 96	K 324	timely manner. * The Maintenance Director will schedule the semi-annual kitchen suppression inspections for each calendar year. Element Two-Identification of at Risk Resident * All residents have the potential to be affected by the practice. Element Three-Systematic Changes * Re-education was provided by the Administrator to the [redacted] regarding ensuring semi-annual kitchen inspections are completed timely and any new equipment installed meets the NFPA code. Element Four- QAPI * The Maintenance Director or his designee will participate in the quarterly local fire inspections. Any citations will be correctly timely and supporting documentation obtained from the vendor who corrected the citation. *An audit tool was created to monitor semi-annual inspection results, to ensure all new equipment is inspected and meets NFPA code. The Maintenance Director or designee will conduct weekly audits for four weeks and then monthly for four months. The results of the audits will be reported to the Administrator and at the monthly QAA meetings as appropriate for further direction.	

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K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observations, record review and interview on 3/18/25 and 3/19/25 in the presence of the US FOIA (b)(6)), it was determined the facility failed to ensure quarterly fire sprinkler systems Inspections, Tests and Maintenance (ITM) were performed in accordance with NFPA 25: 2011 Edition. This deficient practice had the potential to affect all residents and was evidenced by the following: 1. A record review on 3/18/25 revealed: a) There was 1 annual inspection in the last 12 months dated 1/21/25. The previous inspection before the 1/21/25 inspection was dated 2/14/24. There were quarterly and semiannual	K 353	Element One-Corrective Actions * Facility quarterly fire sprinkler system inspections have been scheduled with the vendor to ensure timely completion. The last inspection was January 21, 2025 and the quarterly inspection has been scheduled with the vendor. * A three -year leak test was performed on the dry pipe fire system sprinkler during the sprinkler system inspection. * The penetrations in the kitchen area drop ceiling smoke membrane and above the electrical panels were all sealed. One of the three sprinkler heads in the dishwashing area was missing its	4/9/25

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K 353	Continued From page 13 requirements that were not performed. b) There was no record of a 3 year Air Leak Test performed on the dry pipe fire sprinkler system as required by NFPA 25:13.4.4.2.9. In an interview at the time, the [US FOIA] confirmed the record review and stated, "that was what the sprinkler contractor did." 2. Observations during a facility tour on 3/19/25 from 9:30 AM to 1:00 PM revealed the following: a) The kitchen area had penetrations through the drop ceiling smoke membrane above electrical panels where conduit passed through in 6 places. Also, there were penetrations at the end of the cooking line island where a pipe and wire passed through the drop ceiling. Penetrations in the smoke barrier ceiling membrane allow smoke and hot gases to pass through into the space above bypassing the sprinkler heads and inhibiting sprinkler activation. b) One of three sprinkler heads in the dishwashing area was missing its escutcheon and one sprinkler in front of freezer was missing its escutcheon. c) The social services office had 2 electrical panels with their metal conduit creating penetrations through the drop ceiling above the panels. In interviews at the times, the [US FOIA] confirmed the observations. The facility's [US FOIA (b)(6)] were informed of the deficient practice at the Life	K 353	escutcheon, and one sprinkler head near the freezer was missing the same. All escutcheons were replaced and are functioning. * The 2 electrical panel area penetration in the social services office were properly sealed. Element Two- Identification of at Risk Residents * All residents have the potential to be affect by the practice. Element Three-Systematic Changes * Re-education of the [US FOIA (b)(6)] was completed regarding sprinkler inspections, sealing all penetrations and ensuring all escutcheons are in place. * The sprinkler system vendor will inspect the sprinkler system during required scheduled visits and repair/replace equipment as needed. * Weekly rounding to be completed by Maintenance Director or designee. Any noted needed repairs will be addressed immediately. Element Four-QAPI * The Maintenance Director or his designee will conduct weekly audits for four weeks, monthly for two months, and then semi-annually thereafter, to ensure there are no penetrations and all sprinkler heads and escutcheons are clean and properly functioning. The Maintenance	

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K 353	Continued From page 14 Safety Code exit conference at 4:09 PM. N.J.A.C. 8:39-31.2(e) NFPA 25	K 353	Director will submit a summary of his findings and any inspection reports monthly to the Administrator and to the QAA committee for review.	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.	K 363		4/9/25

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K 363	Continued From page 15 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 3/19/25 in the presence of the US FOIA (b)(6) [redacted], it was determined the facility failed to ensure corridor doors positively latched in accordance with NFPA 101: 2012 Edition, Section 19.3.6.3 and 19.3.6.3.5(1). This deficient practice had the potential to affect 6 residents and was evidenced by the following: Observations during a facility tour between 9:30 AM and 1:00 PM revealed: 1. Resident room 138 corridor door did not latch when tested because the bottom leading edge hit the door frame before the latch could engage the strike plate. 2. The B-wing clean utility room corridor door did not latch when tested because it had thick black tape over the strike hole on the door frame. In interviews at the times, the US FOIA [redacted] confirmed the observations. The facility's US FOIA (b)(6) [redacted] were informed of the deficient practice at the Life Safety Code exit conference at 4:09 PM. N.J.A.C. 8:39-31.2(e)	K 363	Element One-Corrective Actions * An investigation was immediately conducted on March 23, 2025 to ensure all doors properly latch as required. * The latch on door#38 was repaired on March 23, 2025 and now latches in place as required. * The B wing clean utility corridor door latch was immediately repaired on March 23, 2025. Element Two-Identification of at Risk Residents * There were six residents that had the potential to be affected by the practice due to the proximity of their rooms to the corridor doors not properly latching. * An audit was completed om March 23, 2025 to ensure all doors were properly latching. Element Three-Systematic Changes * Staff were in-serviced by the staff educator on the importance of not using tape or any device to block the strike hole of a door frame and to notify Maintenance if a door is not properly latching in the door frame as required.	

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K 363	Continued From page 16	K 363	* The US FOIA (b)(6) were re-educated by the Administrator to check all doors to be sure they latch correctly into the door frame and to ensure no objects impede correct latching. * The Maintenance Director or designee will check doors for proper lactching and function weekly during rounds to ensure closure and latching. Element Four-QAPI *The Maintenance Director or his designee will conduct weekly audits on door latches for four weeks then monthly for two months, then annually thereafter. The Maintenance Director will present the findings of his report monthly for 3 months to the Administrator and the QAA committee for review and further action if needed.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system	K 372		4/9/25

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K 372	Continued From page 17 in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 3/19/25 in the presence of the US FOIA (b)(6) it was determined the facility failed to ensure penetrations through a smoke partition shall be protected by a system or material capable of limiting the transfer of smoke and fire in accordance with NFPA 101: 2012 Edition, Section 8.4 and 8.5.6. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 11:39 AM of the concealed space above smoke door number 9 on the nurses station side of the doors, revealed a 5-inch by 5-inch opening through the double 5/8-inch sheet rock-1 hour fire wall with blue data wires passing through. In an interview at the time, the US FOIA confirmed the observation. The facility's US FOIA (b)(6) were informed of the deficient practice at the Life Safety Code exit conference at 4:09 PM. N.J.A.C. 8:39-31.2(e)	K 372	Element One-Corrective Actions * The space above the Smoke door #9 on the nurses' station side of the doors sheet rock penetration was sealed. Element Two-Identification of at Risk Residents * All residents have the potential to be affected by the practice. Element Three- Systematic Changes * Re-education was provided to the US FOIA (b)(6) regarding repair of all penetrations timely. * An audit was conducted to ensure all penetrations were sealed. * Staff were in-serviced to report in the Maintenance work order log any openings in the ceilings or walls that might be observed especially after vendor visits. * Upon review of the log, any needed repairs will be made timely. Element Four-QAPI *Maintenance Director or designee will conduct weekly audits for four weeks, monthly for two months, and then semi-annually. Needed corrections will be addressed as they are discovered. The results of the audits will be provided to the Administrator and to the QAA committee for 3 months and then semi-annually.	

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K 911 SS=F	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 3/19/25 in the presence of the US FOIA (b)(6) [redacted] it was determined the facility failed to guard live electrical parts in accordance with NFPA 99: 2012 Edition, Chapter 6 and NFPA 70: 2011 Edition, National Electric Code. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations during a facility tour between 9:30 AM and 1:00 PM revealed: 1. There was an electrical outlet directly behind the 2 washing machines and within 6 feet of the water source that was not Ground Fault Circuit Interrupt (GFCI) protected. The outlet had a powerstrip plugged into it and the power strip was suspended by its cord vertically laying across the chemical dispensers and their water lines. 2. The salon had a wall outlet with a broken coverplate. 3. The therapy room washing machine water source had an outlet directly underneath it that was not GFCI protected.	K 911	Element One-Corrective Actions * A new GFCI protected outlet was installed between the two washing machines and the power strip was removed. * A new cover plate was installed on the wall outlet in the beauty salon. * A new GFCI protected outlet was installed in the therapy room near the washing machine. * The wall mounted dehumidifer in the dining room had its wire removed from inside the wall and placed outside on the wall. Element Two-Identification of at Risk Residents * All residents had the potential to be affected by the practice. Element Three-Systematic Changes * Re-education of the US FOIA (b)(6) [redacted] was completed by the Administrator to ensure outlets that	4/9/25

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K 911	Continued From page 19 4. The corridor open to the dining room had a wall mounted dehumidifier with its wire run inside the wall. The wire came outside of the wall and plugged into the outlet. In interviews at the times, the US FOIA confirmed the observations. The facility's US FOIA (b)(6) were informed of the deficient practice at the Life Safety Code exit conference at 4:09 PM. N.J.A.C. 8:39-31.2(e) NFPA 70	K 911	require GFCI breakers have them properly installed. Element Four-QAPI * The Maintenance Director or his designee will conduct weekly audits for four weeks, then monthly for two months, then annually of all outlets in the facility to ensure safety compliance. A monthly report will be submitted to the Administrator and QAA committee for 3 months and then annually.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results.	K 914		4/9/25

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K 914	Continued From page 20 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview on 3/18/25 and 3/19/25 in the presence of the US FOIA (b)(6) [redacted] it was determined the facility failed to ensure non-hospital grade outlets in patient care rooms were tested annually in accordance with NFPA 99: 2012 Edition, Section 6.3.3, 6.3.3.2.1 to 6.3.3.2.4. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations on 3/19/25 between 9:30 AM and 1:00 PM revealed the resident rooms had non-hospital grade outlets. A record review on 3/18/25 revealed there was no inspection and testing reports including: physical integrity, continuity, polarity and blade tension for non-hospital grade outlets in patient care rooms in the last 12 months. In an interview at the time, the US FOIA [redacted] confirmed the record review. The facility's US FOIA (b)(6) [redacted] were informed of the deficient practice at the Life Safety Code exit conference at 4:09 PM. N.J.A.C. 8:39-31.2(e) NFPA 99	K 914	Element One-Corrective Actions * The facility had an electrical inspection of all the resident room outlets that was conducted on June 27, 2024. A copy of the report had been provided to the surveyor. The Maintenance Director retested every outlet in the facility to assure compliance. All testing was completed by April 8, 2025. As needed repairs were identified, the repairs were made immediately. * The electrical vendor was contacted to schedule the next inspection. Element Two-Identification of at Risk Residents * All residents have the potential to be affected by the practice. Element Three-Systematic Changes * Administrator provided re-education for the US FOIA (b)(6) [redacted] and his US FOIA (b)(6) [redacted] regarding the required annual testing of non-hospital grade outlets. All testing was completed by April 8, 2025. Element Four-QAPI * Maintenance Director or designee will conduct random weekly resident room audits for four weeks, then will continue with the required annual testing and inspection to ensure on-going compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315508	A. BUILDING **01** B. WING _____	**03/24/2025**

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**

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K 914	Continued From page 21	K 914	The Maintenance Director will submit a summary of his findings and any inspection reports monthly to the Administrator and QAA committee for review and further action as needed.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power	K 918		4/9/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315508	A. BUILDING 01 B. WING _____	03/24/2025

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

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K 918	Continued From page 22 source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on record review and interview on 3/18/25 in the presence of the US FOIA (b)(6) , it was determined the facility failed to ensure diesel Emergency Powered Supply Systems (EPSS) were tested once every 36 months for 4 continuous hours in accordance with NFPA 110: 2010 Edition, Section 8.4, 8.4.9, 8.4.9.1 to 8.4.9.7. This deficient practice had the potential to affect all residents and was evidenced by the following: A record review of the facilities generator logs revealed there was no documentation that a 4 hour load test was performed in the last 36 months. In an interview at the time, the US FOIA confirmed the record review findings. The facility's US FOIA (b)(6) were informed of the deficient practice at the Life Safety Code exit conference at 4:09 PM. N.J.A.C. 8:39-31.2(e) NFPA 99, 110	K 918	Element One- Corrective Actions * The Maintenance Director completed the 4 hour generator load test on April 3, 2025. Element Two- Identification of at Risk Residents * All residents have the potential to be affected by this practice. Element Three-Systematic Changes. * The US FOIA (b)(6) were re-educated by the Administrator about exercising of the emergency generator every 36 months for 4 continous hours. The Maintenance Director will put a notation in his weekly generator testing log, that will indicate April 2028 is when the next four hour load test will need to be performed, unless the regulation changes. Element Four-QAPI * An audit tool was created to monitor the weekly, monthly, and 4 hour load test(every 36 months) of the generator. The audit will be completed weekly for 3 months, Corrections will be addressed as they are discovered. The results of the audit will be reviewed by the Administrator at the monthly QAA meetings for further direction as deemed appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315508	A. BUILDING **01** B. WING _____	**03/24/2025**

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**

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K 921	Continued From page 23	K 921		
K 921 SS=F	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview on 3/18/25 and 3/19/25 in the presence of the US FOIA (b)(6)), it was determined the facility failed to ensure there was	K 921	Element One- Corrective Actions * The Maintenance Director inspected all Patient Related Eletrical Equipment	4/9/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315508	A. BUILDING **01** B. WING _____	**03/24/2025**

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**

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K 921	Continued From page 24 a program in place with policies and protocols for Inspecting, Testing and Maintaining (ITM) Patient Care Related Electrical Equipment (PCREE) in accordance with NFPA 99: 2012 Edition, Chapter 10. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations during a facility tour on 3/19/25 between 9:30 AM and 1:00 PM revealed the facility had PCREE being used in the residents rooms. A record review on 3/18/25 revealed there was no record of PCREE inspections, tests or maintenance in the last 12 months. In an interview at the time, the [US FOIA] confirmed the record review and stated there is no program ITM of PCREE. The [US FOIA] stated the facility does a monthly bed inspection without keeping a record. The facility's [US FOIA (b)(6)] were informed of the deficient practice at the Life Safety Code exit conference at 4:09 PM. N.J.A.C. 8:39-31.2(e) NFPA 99	K 921	(PCREE) in accordance with NFPA 99. Element Two- Identification of at Risk Residents * All residents have the potential to be affected by the practice. Element Three- Systematic Changes * The [US FOIA (b)(6)] were re-educated by the Administrator regarding implementation of the Patient Related Electrical Equipment testing policy and protocols. Element Four- QAPI * The Maintenance Director will provide an annual Patient Care Related Electrical Equipment inspection report to the QAA committee for review. Any malfunctions wth any patient care equipment will be corrected at the time it is identified. * The Administrator will review the Maintenance logs monthly for three months with the Maintenance Director to ensure all logs are up to date. Findings will be reported to the QAA committee for review and further action as needed.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315508	A. Building B. Wing	5/9/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN POINTE POST ACUTE NURSING & REHABILITATION	3809 BAYSHORE ROAD NORTH CAPE MAY, NJ 08204

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix E0026 Reg. # 483.73(b)(8) LSC	Correction Completed 04/09/2025	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 3/24/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315508 Y1	A. Building 01 - VICTORIA MANOR B. Wing Y2	5/9/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN POINTE POST ACUTE NURSING & REHABILITATION	3809 BAYSHORE ROAD NORTH CAPE MAY, NJ 08204

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0211	04/09/2025	LSC K0222	04/09/2025	LSC K0293	04/09/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0321	04/09/2025	LSC K0324	04/09/2025	LSC K0353	04/09/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0363	04/09/2025	LSC K0372	04/09/2025	LSC K0911	04/09/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0914	04/09/2025	LSC K0918	04/09/2025	LSC K0921	04/09/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
3/24/2025	☐ YES ☐ NO