FEB 2 2 2013

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

PRINTED: 02/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING ______ B. WING ______	C 01/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OCEAN TRAIL HEALTHCARE & REHAB CENTER	630 FODALE AVENUE SOUTHPORT, NC 28461

(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 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to provide care in a manner that maintained her dignity by bathing the resident with her body totally uncovered while she was observed shivering during the bath for 1 of 2 residents (Resident #69) observed being bathed. The findings include: Resident #69 was admitted to the facility on 1/10/11 with diagnoses including CHF (congestive heart failure), osteoporosis, hyperlipidemia, organic brain syndrome and dementia. Review of the most recent annual Minimum Data Set (MDS) Assessment dated 1/18/13 revealed Resident # 69 had short and long term memory problems and was moderately impaired in cognitive skills for daily decision making with decisions poor and requiring cues and supervision. Resident #69 was total assistance for bathing. Review of the resident's balance assessment for moving from a seated to a standing position she was not steady and was only able to stabilize with staff assistance. Review of the resident ' s CAAS (Care Area	F 241	F241 Standard Disclaimer: The Plan of Correction for this alleged deficient practice is provided as a necessary requirement of continued participation in the Medicare and Medicaid program(s) and does not, in any manner constitute an admission to the validity of the alleged deficient practice(s). Resident #69 is being bathed without unnecessary exposure of body parts. Bath blankets as well as towels are now used to cover body parts not being washed until that area needs to be exposed. The C.N.A. that rendered the bath as completed a skills check for bathing with return demonstration to the D.O.N.'s R.N. designee. For those residents having the potential to be affected by the same deficient practice, all C.N.A.'s have been in serviced and gave a return demonstration of this skill to the D.O.N.'s R.N. designee. This review will become a part of the C.N.A. skills checklist annually. The D.O.N. or designee will conduct random checks to ensure measures are taken to prevent unnecessary exposure of residents receiving baths weekly x 4 weeks, then monthly x 3 months. The Plan of Correction for this alleged deficient practice shall be included in the Quality Assurance Committee meeting minutes. Findings related to this Plan of Correction will be presented to the Quality Assurance Committee monthly x 3 months.	2/28/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melanie Long fw HA — TITLE: Administrator — (X6) DATE: 2-22-13

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 241	Continued From page 1 Assessment Summary) dated 1/18/13 revealed Resident #69 triggered for ADLs (activity for daily living). She had short and long term memory problems and required staff to assist with bathing and dressing. 1/30/13 at 8:40 AM NA #1 was observed transporting Resident # 69 down the 100 hall to the 200 hall into the shower room on the 200 hall. Resident #69 was observed sitting in a shower chair. NA #1 was observed taking Resident #69 ' s night gown and adult brief off. NA#1 was observed taking down the shower sprayer and spraying down the resident ' s body including her hair. Resident #69 was observed shivering while NA#1 stopped the water and got a washcloth to bath her. Resident #69 remained uncovered and shaking while NA#1 bathed her face, body, arms. NA #1 was observed using a clean wash cloth and rinsing the areas she had cleaned. NA #1 asked the resident if she would stand and tried to help her get up. Resident #69 was observed shivering and trying to stand but could not stand. NA #1 used the call light to ask for help with standing the resident to clean her bottom. Resident #69 remained uncovered and shivering until NA #2 entered the room at 8:52 AM. NA#1 and NA#2 stood the resident up and she held on the grab bar while NA #2 held her up. The resident was observed shivering and unsteady while NA#1 bathed her bottom. NA#1 asked Resident #69 to open her legs while she was standing and shaking. The resident did not open her legs. At 8:58 AM NA #1 took the sprayer and hosed Resident #69's body. NA#1 and NA#2 were observed walking away from Resident #69 leaving her uncovered while they washed their hands and put on clean gloves. At 8:59 AM NA#1	F 241		

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F 241	Continued From page 2 was observed walking over to Resident #69 and dressing her. Resident #69 was observed not shaking after she was clothed. There were no bath blankets observed in the shower room. During an interview on 1/30/13 at 9:00 am with NA#1 revealed she usually left residents uncovered while she was washing them in a shower chair. She stated the covers got wet when she rinsed them. She further stated Resident #69 shakes all the time and she did not think it was because she was cold. NA #1 stated when Resident #69 receives a bath in the shower chair she usually stands up for her to clean her bottom. NA #1 stated Resident #69 was not standing as well as she usually does. During an interview 1/30/13 on 3:51 PM the DON (Director of Nursing) stated she expected Nursing Assistants to treat residents with dignity. She stated when residents receive a bath in the shower chair staff should work on one section of the body at a time. The section they are not working on should be covered with a bath blanket.	F 241		
F 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observations with resident & staff	F 252		

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F 252	Continued From page 3 interviews the facility failed to maintain a homelike environment for 1 of 1 resident with a mechanical lift stored in his rooms. (Resident #60). Findings include: Resident #60 was admitted to the facility on 3/17/2008 with diagnoses of epilepsy, intellectual disability, paranoid schizophrenia, and glaucoma. The quarterly admission Minimum Data Set (MDS) assessment was completed on 12/3/12. The resident was assessed to have a brief interview mental status score of 10 out of 15 in cognition. He was coded as needing supervision for daily activities and was independent in ambulation in his room and eating. The resident was not steady but could stabilize himself without human assistance. Resident # 60 had impairment on both sides for upper and lower extremities. The resident had impaired vision. He could understand others and could usually make himself understood. During the initial tour of the facility on 1/28/13 at 11:50 AM a yellow PARKING sign was observed on resident #60's doorframe (room # 109). A mechanical lift had been placed up against the unoccupied bed with the 2 leg metal base pushed under the bed. Resident #60 was not in room #109 during the observation. Nursing Assistant (NA) #5 was observed on 1?28/13 at 12:55 PM rolling a mechanical lift into room #109. She " parked " the mechanical lift over the unoccupied second bed. The 2 metal leg bases were placed under the bed with the swinging arm section hanging directly over the	F 252	F252 Standard Disclaimer: The Plan of Correction for this alleged deficient practice is provided as a necessary requirement of continued participation in the Medicare and Medicaid program(s) and does not, in any manner constitute an admission to the validity of the alleged deficient practice(s). Resident #60 does not require the use of a mechanical lift. The lift has been removed from the room of resident #60. For those residents having the potential to be affected by the same deficient practice, lifts will be stored in unoccupied rooms and/or designated storage rooms. The maintenance and housekeeping supervisors or their designee will monitor resident rooms for storage of lifts weekly x 4 weeks, and monthly x 3 months. If lifts are found in occupied patient rooms, they will be removed promptly. Nursing staff will be inserviced on proper storage of lifts. Lifts are not charged in resident rooms. The battery detaches and is charged on a wall mount charger in the maintenance office. The Plan of Correction for this alleged deficient practice shall be included in the Quality Assurance Committee meeting minutes. Findings related to this Plan of Correction will be presented to the Quality Assurance Committee monthly x 3 months.	2/28/13

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F 252	Continued From page 4 mattress. Resident # 60 was in the room sleeping. A review of the care plan for Resident #60 revealed he was at risk for falls and side effects from antipsychotic medications. Interventions included a clutter free environment, staff assistance as needed, and monitoring of medications and behaviors. A review of the medical record revealed the resident was being followed by psychiatric services. He was last seen on 1/17/13. The Psychiatrist documented the resident had pleasantly confused thoughts with improved associations. An interview was conducted with NA #5 on 1/28/13 at 12:55 PM. She stated staff stored lifts in empty rooms and put the sign " PARKING " on the door so the lift could be located quickly. She stated the lifts were also stored in storage rooms and bathrooms. The NA revealed there were many empty rooms due to one hall being updated. She indicated she placed the lift in room #109 because there was an empty bed and it was convenient for staff to use. An interview was conducted with Resident #60 on 1/29/13 at 12:05 PM. The resident stated staff just rolled the lift machine into his room and left it over the other bed. He revealed staff never asked him if it bothered him or if the lift was in his way. The resident stated the lift stayed over the other bed most of the time and staff took it in and out of his room during the day and at night... Resident #60 revealed he did not know why it was put in his room He stated some rooms did	F 252		

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F 252	Continued From page 5 not have anybody in them. The resident revealed he wished staff would put the lift some other place. During an interview on1/30/13 at 11:40 am the facility Administrator stated staff should store mechanical lifts in empty rooms and storage areas. Administrator indicated staff should not be charging them in occupied rooms. The Administrator stated her expectation was that staff would store and charge the mechanical lifts in rooms that did not house residents.	F 252		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions	F 441		

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F 441	Continued From page 6 from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews the facility failed to maintain a record of an infection by failing to track the infection for a resident diagnosed with viral conjunctivitis (Resident #65). Resident #65 was admitted to the facility on 1/21/09 and re-admitted on 1/17/11 with diagnoses including Anemia, Hypertension and Dementia. Review of the most recent quarterly Minimum Data Set (MDS) Assessment dated 12/3/12 identified resident #65 as cognitively intact and able to perform all of her own Activities of Daily Living. Resident #65 used a walker to ambulate in her room and in the facility. Review of the physician communication log dated 12/31/12 read in part, " c/o (complaint of) eye still running " water " never completely cleared up from antibiotic ointment. "	F 441	**STANDARD DISCLAIMER:** F441 Standard Disclaimer: The Plan of Correction for this alleged deficient practice is provided as a necessary requirement of continued participation in the Medicare and Medicaid program(s) and does not, in any manner constitute an admission to the validity of the alleged deficient practice(s). Resident #65 had a diagnosis of viral conjunctivitis in both eyes according to physician consultation 01/04/13. Artificial tears and warm compresses were ordered. The physician also noted that "the viral conjunctivitis is/can be contagious". Resident #65 was not placed on the infection control log to track her conjunctivitis however, isolation precautions were implemented according to nurses note dated 1/4/13 5:15 P.M. Patient education, staff notification as well as notification of family member are noted also. For those residents having the potential to be affected by the same alleged deficient practice, the licensed nurses were in serviced by the interim Director of Nurses. SPICE recommendations as well as facility policy was reviewed. All licensed nurses will be in-serviced on implementation of isolation precautions to include instructions on the completion of the Infection Control Report by the IDON or her designee, complete by 2/28/13. All CNA's were inserviced on standards of practice on infection control. The IDON or RN designee will incorporate the implementation of isolation precautions into the annually required infection control in-service. The P.A.R. and Q.A. committee will monitor residents identified through the QA process until such infection and any identified trends are resolved. The Plan of Correction for this alleged deficient practice shall be included in the Quality Assurance Committee meeting minutes. Findings related to this Plan of Correction will be presented to the Quality Assurance Committee monthly x 3 months.	2/28/13

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F 441	Continued From page 7 Review of the physician ' s orders dated 12/31/12 revealed resident #65 was to have a follow up visit with Optometry related to her watery eyes. Review of the consultation dated 1/4/13, revealed that resident #65 had a diagnosis of Viral Conjunctivitis in both eyes. Artificial tears were ordered and cool compresses as needed. The physician also noted that viral conjunctivitis " is/can be contagious. " Review of the Infection Control report for the month of January 2013 showed that resident #65 was never placed on the infection control log. During an interview with Nurse #1 on 1/30/13 at 9:30am she stated that she remembered resident #65 was ordered artificial tears and a lot of hand washing was done; however, she could not remember if the resident was on any type of contact isolation. During an interview with the Director of Nursing on 1/30/13 at 3:15pm she stated that typically she receives a copy of the physician ' s orders and from this places the resident in the infection control log book. She stated that apparently she did not get a copy of the order and the resident ' s conjunctivitis was not tracked.	F 441		

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	345373	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	03/05/2013

MAR 26 2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OCEAN TRAIL HEALTHCARE & REHAB CENTER	630 FODALE AVENUE SOUTHPORT, NC 28461

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K 000	INITIAL COMMENTS Surveyor: 27871 This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type I-fire restance construction, one story. Building one does not have a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations, and staff interview at approximately 10:00 am onward, the following items were noncompliant, specific findings include: corridor door to were Med. records storage room, could not be confirmed to be 3/4 hour fire rated(room is located on 100 hall).	K 029	K029 The Plan of Correction for this alleged deficient practice is provided as a necessary requirement of continued participation in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s). No resident's were specifically identified as having been affected by this alleged deficient practice. For those resident's having the potential to be affected by the same alleged deficient practice, A one-hour fire-rated door has been ordered to replace the corridor door to medical records storage. The maintenance director or designee conducted a check of other doors to storage areas to ensure the doors were one-hour fire rated. No other non-rated doors were found. The maintenance director will complete monthly checks of all storage for one calendar quarter and then quarterly thereafter. Findings of this plan of correction will be presented to the Quality Assurance Committee monthly for (3) three months.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Melanie Long / Dosunwan	Administrator	3/23/13

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K 029	Continued From page 1 42 CFR 483.70(a)	K 029		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations, and staff interview at approximately 10:00 am onward, the following items were noncompliant, specific findings include: dry storage door in kitchen, requires two motion's of hand to open door to exit access. 42 CFR 483.70(a)	K 038	K38 The Plan of Correction for this alleged deficient practice is provided as a necessary requirement of continued participation in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s). No resident's were specifically identified as having been affected by this alleged deficient practice. For those resident's having the potential to be affected by the same alleged deficient practice, The maintenance director or designee has inspected all doors to ensure only one hand motion is needed to exit the room. No other door- knobs were found to need replacement. The maintenance director or designee shall complete rounds monthly x 3 months, then quarterly thereafter to identify door-knobs requiring more than 1 hand motion to exit the room. Door-knobs will be replaced immediately if found. Findings related to this plan of correction will be presented to the Quality Assurance Committee monthly x (3) three months.	
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations, and staff interview at approximately 10:00 am onward, the following items were noncompliant, specific findings include: multi-plug wall adapter being used for TV to be plugged into for permanent power(room 308). 42 CFR 483.70(a)	K 147		

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	345373	A. BUILDING 02 - BUILDING 02 B. WING ____	03/05/2013

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(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 000	INITIAL COMMENTS Surveyor: 27871 This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type III protected, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000		
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations, and staff interview at approximately 10:00 am onward, the following items were noncompliant, specific findings include: multi-plug wall adapter is being used for TV to be plugged into for permanent power(room 401). 42 CFR 483.70(a)	K 147	K147 The Plan of Correction for this alleged deficient practice is provided as a necessary requirement of continued participation in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s). No resident's were specifically identified as having been affected by this alleged deficient practice. For those resident's having the potential to be affected by the same alleged deficient practice, The multi-plug being used for TV to be plugged into for permanent power in rooms 401 and 308 have been removed. The maintenance director or designee will conduct rounds weekly x 4 weeks, monthly x 3 months and quarterly thereafter to ensure multi-plugs are not in use. Multi-plugs will be removed immediately. Residents and/or their families will be reminded that multi-plugs and surge protectors are not permissible. Additionally, the admission packet of new residents will include notice-stating multi-plugs or surge bars are not permissible This plan of correction and the results of the monitoring tool will be presented to the Quality Assurance Committee monthly.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Melanie Long / NOS...	administrator	3/23/13

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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