NAME OF PRO OCEAN TRA (X4) ID PREFIX TAG F 223 SS=J	(EACH DEFICIENC REGULATORY OR I 483.13(b), 483.13(c)(ABUSE/INVOLUNTA The resident has the sexual, physical, and punishment, and invo	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	A. BUILDING B. WING ID PREFIX TAG F 22	STREET ADDRESS, CITY, STATE, ZIP CODE 630 FODALE AVENUE SOUTHPORT, NC 28461 PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AL DEFICIENCY) 23	RECTION SHOULD BE	MPLETED C 01/17/2014 (X5) COMPLETION DATE
OCEAN TRA (X4) ID PREFIX TAG F 223 SS=J A SS=J	AIL HEALTHCARE & RI SUMMARY ST (EACH DEFICIENC' REGULATORY OR I 483.13(b), 483.13(c)(ABUSE/INVOLUNTAI The resident has the sexual, physical, and punishment, and invo	EHAB CENTER ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) (1)(i) FREE FROM RY SECLUSION right to be free from verbal,	ID PREFIX TAG	630 FODALE AVENUE SOUTHPORT, NC 28461 PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION SHOULD BE	01/17/2014 (X5) COMPLETION
OCEAN TRA (X4) ID PREFIX TAG F 223 SS=J A SS=J	AIL HEALTHCARE & RI SUMMARY ST (EACH DEFICIENC' REGULATORY OR I 483.13(b), 483.13(c)(ABUSE/INVOLUNTAI The resident has the sexual, physical, and punishment, and invo	EHAB CENTER ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) (1)(i) FREE FROM RY SECLUSION right to be free from verbal,	ID PREFIX TAG	630 FODALE AVENUE SOUTHPORT, NC 28461 PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION SHOULD BE	(X5) COMPLETION
OCEAN TRA (X4) ID PREFIX TAG F 223 SS=J A SS=J	AIL HEALTHCARE & RI SUMMARY ST (EACH DEFICIENC' REGULATORY OR I 483.13(b), 483.13(c)(ABUSE/INVOLUNTAI The resident has the sexual, physical, and punishment, and invo	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) (1)(i) FREE FROM RY SECLUSION right to be free from verbal,	PREFIX TAG	630 FODALE AVENUE SOUTHPORT, NC 28461 PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION SHOULD BE	COMPLETION
(X4) ID PREFIX TAG F 223 SS=J	SUMMARY ST, (EACH DEFICIENC) REGULATORY OR I 483.13(b), 483.13(c)(ABUSE/INVOLUNTA The resident has the sexual, physical, and punishment, and invo	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) (1)(i) FREE FROM RY SECLUSION right to be free from verbal,	PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETION
F 223 SS=J	(EACH DEFICIENC REGULATORY OR I 483.13(b), 483.13(c)(ABUSE/INVOLUNTA The resident has the sexual, physical, and punishment, and invo	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) (1)(i) FREE FROM RY SECLUSION right to be free from verbal,	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETION
TAG F 223 4 SS=J 4	REGULATORY OR I 483.13(b), 483.13(c)(ABUSE/INVOLUNTA The resident has the sexual, physical, and punishment, and invo	(1)(i) FREE FROM RY SECLUSION right to be free from verbal,	TAG	CROSS-REFERENCED TO THE A DEFICIENCY)		
SS=J 4 - - - - - - - - - - - - - - - - - - -	ABUSE/INVOLUNTA The resident has the sexual, physical, and punishment, and invo	RY SECLUSION right to be free from verbal,	F 22	23		
- - - i	The resident has the sexual, physical, and punishment, and invo	right to be free from verbal,				1/20/14
- - - 1	sexual, physical, and punishment, and invo	•				
-	punishment, and invo	mental abuse, corporal				
	•					
i	The facility must not u	oluntary seclusion.				
i		use verbal, mental, sexual,				
		rporal punishment, or				
	involuntary seclusion.					
b	This REQUIREMENT	「 is not met as evidenced				
	by:			5000		
		iew, staff, resident and adult terviews, the facility failed to		F223 Standard Disclaimer:		
		8) of 4 sampled residents		This Plan of Correction is a neo	cessary	
, I	was free of verbal abo	use, failed to provide an		requirement to participate in the		
		Resident #2) of 4 sampled d free of physical and verbal		and Medicaid program(s) and c any manner, constitute an adm		
		rotect 1 (Resident #1) from		the validity of the alleged defici		
	verbal and physical a			practice(s).		
		began on 1/1/14 and was at 10:00 AM. Immediate		F223		
		ed on 1/17/14 at 1:55 PM		Resident #8 expired at the hos	pital on	
	· ·	ided a credible allegation of		01/13/14 for reasons unrelated		
	compliance.			allegations cited in F223. A rep		
	The facility will remain	n out of compliance at a		abuse was made to the ADON 01/03/14. The incident is alleged		
		f D (no actual harm with		occurred on 01/01/14. The Adr		
	potential for more that	in minimal harm that is not		was notified of the allegation re		
	• • • • •	to complete training on		Resident #8 by the ADON on 0		
	monitoring of its corre	e staff and to implement the active action.		NA #1 s employment was sus 01/06/14 pending an investigat	•	
				allegations related to Resident		
-	The findings included	l:		Administrator conducted an inv	restigation	
	1 Desident #9 was a	dmitted to the facility on		into the allegations involving Re		
		dmitted to the facility on noses that included COPD		The Administrator, based on wi	niien	1

Electronically Signed

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.

02/07/2014

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		(X3) DATE SURVEY COMPLETED	
			A. BOILDING		с	
		345373	B. WING		01/17/2014	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
	RAIL HEALTHCARE & R			630 FODALE AVENUE		
UCEAN T				SOUTHPORT, NC 28461		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETIC	
F 223	Continued From page	e 1	F 22	3		
		Pulmonary Disease),		concluded the investigation on 01	1/08/14	
		and Alzheimer 's Disease.		and could not substantiate the all		
		charged to the hospital on		NA#1 returned to work on 01/10/	-	
	1/7/14 where she late	er expired.		did not return to the care and ser	vices of	
				Resident #8. The Administrator		
		ssment (CAA) for Cognitive		completed a 24-Hour and 5-Day		
		revealed that the resident y responsive with periods of		Report specific to the allegations NA#1 and Resident #8 on 01/15/	-	
		s able to understand others		submitted the reports to the North		
	-	known. The CAA for Visual		Carolina Healthcare Personnel R		
		13 revealed that the resident		(NCHCPR) on 01/15/14. NA #1		
	had a history of catar vision was impaired.	acts and the resident ' s		employment was terminated on C)1/16/14.	
	The Quarterly Minimu					
		/3/14 revealed that the rely intact and vision was		Currently, Resident #2 reports feature and free from any and all physical		
	highly impaired.			verbal abuse. On 01/05/14, Resi		
	inging inputou			reported having been mistreated		
	The Care Plan dated	10/21/13 revealed that the		unnamed staff member to Med A		
		ned about her health and was		Resident #2 described the staff n		
		ttention from the staff. The		to Med Aide #2. Med Aide#2 rep		
		ff to approach the resident		allegation to the ADON on 01/05/		
	warmly at all times.			Pursuant to the facility s Abuse the accused staff member, NA #1		
	A review of the facility	y ' s Grievance Log revealed		re-assigned to non-resident care		
	an entry dated 1/2/14			the laundry on 01/05/14. The AD		
	-	n rudely to Resident #8. A		began an investigation on 01/05/		
	written statement by	Med (medication) Aide #1		Administrator suspended NA #1	S	
		Resident #8 rang the call bell		employment 01/06/14, based on		
		ne room and asked the		allegations related to Resident #2		
		anted. According to the Resident stated that she		Administrator s receipt, on 01/06 an additional allegation involving		
		and ice and wanted some		#8 and NA#1. The Administrator		
		revealed that the NA stood		conducted an investigation into the	ne l	
		it in an intimidating way and		allegations involving Resident #		
		ident that when she rang her		8. Resident #2 was interviewed I		
		to tell her everything she		the ADON, and Social Worker rel		
	needed right then an	d to stay off her call light.		the allegations involving NA#1. R	esident	

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If continuation sheet Page 2 of 54

		MEDICAID SERVICES				<u>VO. 0938-03</u>	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	. ,	TE SURVEY MPLETED	
DIERIO	CONTRECTION	DENTIFICATION NOMBER.	A. BUILDING	G			
		245272	B WINC			C	
		345373	B. WING			01/17/2014	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE		
OCEAN TI	RAIL HEALTHCARE & R	EHAB CENTER		630 FODALE AVENUE			
				SOUTHPORT, NC 28461			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICII	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIC DATE	
F 223	Continued From page	e 2	F 22	23			
	The statement revea			#2⊡s accounts of both t	he allegation and		
		nrowing her hands in front of		the description of the ac	-		
	her to push the NA a	-		one interview to the nex			
				Administrator, based on			
	On 1/14/14 at 5:40 P	M the Administrator stated in		resident and staff intervi			
		incident with Resident #8		the investigation on 01/0			
		Aide #1 who heard the		not substantiate the alle			
		ng outside the building. The		either of the identified re			
		that Resident #8 denied the		Subsequent to the Admi			
	incident and the resid	dent had since expired.		investigation, NA#1 retu			
	Poviow of the facility	's investigation revealed a		01/10/14, but did not ret and services of Residen			
	written complaint was	-		Administrator completed			
	-	^r Nursing) that a NA spoke		5-Day Working Report s			
	-	3. The note revealed that the		allegations involving NA	-		
	-	and had no complaints per		# s 2 and 8 on 01/15/14			
	the social worker. Th	e investigation note revealed		the reports to the North	Carolina		
		interviewed and reported		Healthcare Personnel R			
		eated in any way. A written		on 01/15/14. NA #1⊡s e			
	-	de #1 revealed that on 1/2/14		terminated on 01/16/14.	•		
		dent #8 rang her call light		Social Worker shall prov			
		ved to enter the room and		reassurance on a week			
	asked the resident w	hat the resident stated that		and monthly x 3 months to ensure the resident fe			
		oda and ice and wanted		from abuse. Resident #2			
		ement read: "Name of NA		by a psychological servi	•		
	#1 stood in front of re			basis, as ordered prior to			
	intimidating way, told	her when she rings her call		incident, for psychothera	-		
	• •	thing she needs right then		continue as ordered by I			
		II light. Name of Resident #8		physician and psychothe	erapist.		
		vas throwing her hands in					
	-	lame of NA #1 off of her and		Resident #1 expired on			
	yelling get out of my	race. "		reasons unrelated to the	-		
	The Administrator atc	ated in an interview on		in F223. (a)The DON sta			
		that she spoke with NA #1		reported to her by an NA recall which NA, that the			
		d the NA could not recall any		NA#1 tell resident #1 that			
	unusual interactions			fell out of the wheelchai	-		
				also told there were two			

Facility ID: 923382

If continuation sheet Page 3 of 54

		MEDICAID SERVICES				NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>	PLE CONSTRUCTION		ATE SURVEY
						С
		345373	B. WING)1/17/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	ZIP CODE	-
				630 FODALE AVENUE		
UCEAN I	RAIL HEALTHCARE & R			SOUTHPORT, NC 28461		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	NOF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETIO DATE
F 223	Continued From page	e 3	F 22	23		
. 220		PM the facility ' s Social	1 22	present. According to th	na DON, sha shoka	
		nterview that Resident #8		with those two family m	-	
		nd oriented and reliable with		denied hearing any suc		
		The Social Worker stated		anyone to any resident		
		sident if any of the girls that		The DON did not report		
	help her get dressed	had mistreated her in any		the Administrator. (b) A		
	-	stated: "No." The Social		NA#2 make specific alle	•	
		ne has had no complaints		related to Resident #1 of		
	about NA #1 from oth	ner residents.		#3. Rather, NA#2 aske		
				general, non-specific re		
		ephone interview on 1/15/14 never yelled at Resident #8		questions related to abut in the 2567, Nurse #3 in	•	
	or had any problems	-		appropriately to report a		
		with the resident.		abuse. NA#2 failed to re		
	Med Aide #1 stated ir	n an interview on 1/15/14 at		allegations of abuse sp		
	2:40 PM that Resider	nt #8 was unable to see very		Resident #1. Based or		
	well and knocked over	er her drink several times on		contained in the 2567 a	and based on staff	
	U U	. The Med Aide stated that		interviews, the alleged i		
		e resident her medication		at an undetermined time		
	-	out of the room and NA #1		Administrator complete	-	
		esponse to the call light. The		and filed a 24-Hour 01/		
		NA looked irritated. The Med		5-Working Day Report	on 01/22/14.	
		left the resident ' s room and ler and into the courtyard to				
	smoke. The Med Aide	-		For those residents hav	ving the potential to	
		ard outside the room of		be affected by the same	• .	
		Id hear NA #1 yelling at the		deficient practice:		
		window. The Med Aide				
		" I ' m going to get this up		1. All staff were re-ed	ucated on the	
	this time but next time	•		facility⊡s Abuse Policy(
		and stay off the call light. "		the staff received education		
		that NA #1 was standing		identification and report		
		n intimidating way and the		abuse, neglect, mistrea		
	-	her arms and saying: "Get		misappropriation of resi		
		Aide stated that NA#1 did		and/or injuries of unkno	wit oligili.	
		t but was raising her voice s face. The Med Aide stated				
		incident to Nurse #3 who		2. The Administrator a	and/or Social	
		The Med Aide stated that		Worker will conduct ran		

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/17/2 FORM APPRO OMB NO. 0938-03
TATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345373	B. WING		C 01/17/2014
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	
				630 FODALE AVENUE	
OCEAN II	RAIL HEALTHCARE & R			SOUTHPORT, NC 28461	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED DEFICI	ACTION SHOULD BE COMPLETI TO THE APPROPRIATE DATE
F 223	Continued From page	o. 4			
1 225			F 22		
		d the 7AM-3PM shift but that		interviews, with a minim	
	day had stayed over shift as well.	and worked the 3PM-11PM		interviewable residents	-
	shint as well.			x 4, then a minimum of	
	Δ review of the pource	oll time sheet for NA #1		interviewable residents quarterly x 4 for any res	-
		ked 7AM to 11PM on 1/1/14		specific to abuse, negle	
	and 7AM-3PM only c			misappropriation of resid	
				and/or injuries of unknow	
	In an interview with N	/led Aide #1 on 1/15/14 at		such findings will be rep	
		de stated that she thought		Administrator immediate	
		urred on 1/2/14. The Med		investigation will be con	-
	Aide stated that on F	riday (1/3/14) she reported		the facility s Abuse poli	
		sistant Director of Nursing		Administrator shall repo	
	(ADON) and was told	d to write it up. The Med Aide		abuse, neglect, mistreat	-
	stated that she got be	usy and did not write up the		misappropriation of resid	dent property
	incident until Monday	/ 1/6/14. The Med Aide		and/or injuries of unknow	wn origin using the
	stated that the incide	nt must have occurred on		24-Hour and 5-Working	Day Reports.
	1/1/14.			Such reports shall be file	ed timely to the
				NCHCPR. Residents wi	
		ted in an interview on 1/15/14		their right to be free of a	
		ad heard NA #1 yelling at times one evening. The		and to whom to report a	ny concerns.
		that he heard NA #1 tell the		3. For those residents	
		s doing the best she could,		communicate their need	
		nd to stop bothering her. The		shall conduct weekly ski	
	-	able to provide the date or		and shall report any sus	-
		The Housekeeper stated that		neglect, mistreatment, a	-
		ay the NA was talking to the		unknown origin. Such a	
	resident to be verbal	auuse.		be on-going and any sus shall be reported to the	
	2 Resident #2 was a	admitted to the facility on		and/or Director of Nursi	
	5/14/13 and had diag	•		Following any such repo	5
	-	e, Dementia with Lewey		Administrator shall follow	
	Bodies, Stroke, and I	-		policy related to the ider	
				investigation, and report	
	The Care Area Asses	ssment (CAA) for Cognitive		suspicions. All allegatio	-
		revealed that that resident		neglect, mistreatment, n	
		e with her husband but he		resident property and/or	
		e the amount of care		unknown origin shall be	

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						NO. 0938-03	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY	
			A. BUILDING			С	
		345373	B. WING		_ (01/17/2014	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST		•	
0054117				630 FODALE AVENUE			
OCEAN II	RAIL HEALTHCARE & R	EHAB CENTER		SOUTHPORT, NC 2846	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE	
F 223	Continued From page	e 5	F 22	3			
	needed. The CAA rev	vealed.the resident was		24-Hour and 5-Wor	rking Day Reports.		
	verbally responsive, o	could make her needs		Such reports shall I	be filed timely to the		
	known and was able	to understand others. The		NCHCPR.			
	CAA for Activities of [Daily Living (ADLs) revealed					
		ired assistance with ADLs		4. The Corporate	Nurse Consultant shall		
	and it was unsafe for	the resident to transfer		-	terviews (5 employees		
	independently.				department⊡s staff to		
				include all three shi			
	The Quarterly Minimu	um Data Set (MDS)			three months, and for		
		2/12/13 revealed that the		4 quarters (i.e. 3 co			
	resident was severely	y cognitively impaired and		thereafter to ensure	-		
	-	ssistance with transfers.		understanding of th	ne abuse policy related		
				to the identification			
	The Care Plan dated	5/31/13 revealed that		abuse, neglect, mis			
		aired thought processes due		misappropriation of			
	-	entia. The Care Plan listed a			nknown origin. Staff		
		mobility due to Parkinson 's		who are unable to	•		
		interventions was for staff to					
				required competen			
	and to use the stand	and ambulation as necessary up lift for transfers.		reporting of abuse,	o the identification and neglect, mistreatment,		
		It note dated 1/2/14 revealed		misappropriation ar	-		
		It note dated 1/3/14 revealed			the Corporate Nurse		
	-	orted that she did not know			nce of such interviews urse Consultant shall		
	whether or not it reall	• • • •					
	which she felt badly r	with a staff member during		be provided to the			
				written format, wee			
		chologist discussed his		monthly for three m			
		t to be more assertive about		quarters thereafter.			
		n cases like this to discuss		•	clude date, staff name,		
	with the facility staff.				mentation of proficiency		
	Deview of "			(ies) related to the			
		's schedule revealed Nurse			ent, misappropriation of		
		to 11PM on 1/5/14. A review			nd injuries of unknown		
		revealed an entry dated		origin. Any findings			
		Nurse #1 that Resident #2		abuse, neglect, mis			
		y shift on her first medication		misappropriation of			
		rsing assistant) was verbally		-	nknown origin will be		
		r and that she was scared			ninistrator immediately		
	about her safety. The	e note revealed that the		and an investigation	n will begin per the		

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		MEDICAID SERVICES					0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED	
			A. BUILDING	G		(C	
		345373	B. WING				_ 17/2014	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		1		
				63	0 FODALE AVENUE			
UCEAN II	RAIL HEALTHCARE & R			SOUTHPORT, NC 28461				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 223	Continued From page	e 6	F 22	23				
	resident had also rep	orted this very tearfully to le #2. A nurse ' s note dated			facility⊡s Abuse Policy.			
		y Nurse #1 revealed that the			The Administrator shall monitor items 1			
	resident was still voicing concern for her safety stating: "I'm just so scared because she is so				4 above for compliance, and shall certif	-		
	big and all I can do is				such evidence of monitoring in a written monthly monitoring report.	1		
	Review of the facility	's Grievance Log revealed			The Plan of Correction for this alleged			
		that a NA was rough and			deficient practice(s) has been			
	spoke rudely to Resid				incorporated into the facility s most recent Quality Assurance Committee			
	A review of the facility written statement dat			meeting minutes and shall be evaluated for effectiveness no less than monthly for				
	-	ned that the NA with a ring in			three months and quarterly thereafter.			
	her lip was rough with	n ner and spoке ⁻ during care this morning.						
	The statement reveal							
	-	NA was rough with her and						
		the side of the wheelchair						
		wasn ' t going to put up with nent revealed that the						
	-	e NA no longer work with						
	her.							
	A written statement d	ated 1/5/14 by Med Aide #2						
		nt #2 was observed in her						
		stated that she was being						
	•	and referred to the NA as						
	reported that the NA	#2 wrote that the resident kicked her.						
		lated 1/5/14 by NA #1						
		d NA #2 went in to get he resident was yelling and						
		ng care. The NA reported						
	-	n to get the resident up and						
	the resident continue	d to yell as they got her up						
	and dressed. NA #1 v	wrote in her statement that		- 1				

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG_			PLETED
		345373	B. WING				C 17/2014
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 01/	17/2014
				6	630 FODALE AVENUE		
OCEAN T	RAIL HEALTHCARE & RI	EHAB CENTER		5	SOUTHPORT, NC 28461		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 223	Continued From page	27	F	223	3		
	1/6/14 revealed an int where the resident re came in her room on told her it was time to revealed that the resid to get up and the NA and you are going to The report revealed th screaming and the NA The statement reveal she told the NA to lea continued to get her of statement revealed th the same NA had wor a similar situation with report the incident to	A told her to "shut up." ed the resident stated that ive her alone and the NA dressed and out of bed. The nat the resident stated that rked with her before and had in her last week but did not the staff. The report					
	it to her psychologist more assertive about	dent stated she did mention who encouraged her to be her care and this was why g at the NA yesterday that et up.					
	12:35 PM revealed R	vorker dated 1/13/14 at esident #2 stated in an not feel that any other staff ated her.					
	interview that the NAs with her. The Resider already spoken with t Protective Services) a about the incident. Du Resident was able to another state. The Re falling a lot and her her	M Resident #2 stated in an s move fast and are rough nt stated that she had he social worker (Adult and did not want to talk uring the interview the recall that she was from esident stated that she was usband could no longer take oved here to be closer to					

If continuation sheet Page 8 of 54

		MEDICAID SERVICES				IO. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	· · ·	TE SURVEY MPLETED	
		345373	B. WING			С	
		345373		STREET ADDRESS, CITY, STATE, ZIP COD	01/17/2014		
NAME OF P	ROVIDER OR SUPPLIER				E		
OCEAN T	RAIL HEALTHCARE & R	EHAB CENTER		630 FODALE AVENUE SOUTHPORT, NC 28461			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 223	Continued From page	e 8	F 22	23			
. 220		stated that her husband lived	1 22				
	close by with a family						
	On 1/14/14 at 1:50 PM, an interview was						
		2 who assisted NA #1 with					
		on the morning of 1/5/14.					
		he went in to assist NA #1 to					
		ut had to leave the room					
		on of care. The NA stated					
	NA #1 while she was	ess inappropriate behavior by in the room.					
		n an interview on 1/14/14 at 14 she observed Resident #2					
		hair in the hall with no shoes					
	•	ated that the resident was					
		hat the girls were jerking her					
	around and had kicke	ed her and did not like it and					
		e Med Aide stated that after					
		vas at the nurse 's desk and					
		if she had called anyone to					
	had a witness.	stated she was glad she					
	Nurse #1 stated in ar	n interview on 1/14/14 at 5:20					
		ot to Resident #2 on her med					
		of 1/5/14, the resident was					
		e Nurse stated that the e was slung around in the					
		he ring in her lip. Nurse #1					
	•	is the only NA with a lip ring					
		was assigned to Resident					
	#2. Nurse #1 stated t	that when she asked NA #1					
		p that morning the NA replied					
		e resident up when she was					
		The Nurse stated she told the					
		have to yell at her and the NA ust the way she talked to					
	stated that this was p	usi ine way she laineu lu	1			1	

Facility ID: 923382

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE COMF	E SURVEY PLETED	
		345373	B. WING				C / 17/2014	
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	·		
OCEAN T	RAIL HEALTHCARE & RI	EHAB CENTER		630 FODALE AVENUE SOUTHPORT, NC 28461				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 223	way NA #1 spoke to h did not know the resid bedtime when the resid bedtime when the resid the ring in her lip had stated that she looked where the resident pois sign of injury. The Nu already given her stat and did not know abor her statement. The N had trouble getting th always been oriented that when the residen she knew it was the w stated that at the time Resident #2 was scan stated that on Saturda NA #1 from a distance " I guess they are not On 1/15/14 at 7:15 Al report at 11:00 PM or Nurse #1 and Med Ai came out in tears and door closed, NA #1 w her and kicked her ar on for a week. The N was believable. The N resident responded a and talked like she hat totally oriented to place On 1/15/14 at 12:25 F Worker stated in an ir level of orientation flu exact in relation to tim stated that the resider round about time fram	her. Nurse #1 stated that she dent had been kicked until kident told her the NA with kicked her. The Nurse d at the resident 's thigh binted and did not see any rse stated that she had tement about the incident ut the kick when she wrote urse stated that Resident #2 e right word out but had with her. The Nurse stated it did say the wrong word wrong word. The Nurse e of the incident on 1/5/14, red of NA #1. The Nurse ay 1/11/14 the resident saw e several times and stated: going to fire her. " M, Nurse #3 stated that in a 1/5/14 she was told by de #2 that Resident #2 I stated that as soon as the as pulling and tugging on ad that this had been going urse stated that the ppropriately to questions ad some sense but was not	F	22:	3			

Facility ID: 923382

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						O. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION	· · ·	E SURVEY IPLETED
			A. DOILDING			С
		345373	B. WING		0,	1/17/2014
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	RAIL HEALTHCARE & R			630 FODALE AVENUE		
UCEAN II		ERAD CENTER		SOUTHPORT, NC 28461		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIOI DATE
F 223	Continued From pag	e 10	F 22	3		
		that the resident told her				
		n 1/6/14 that a NA came in				
	her room around 6:00	0 AM to get her up and she				
		did not want to get up and				
		she had her all day and she				
		old her to do. The Social e resident told her that she				
		id the NA told her to shut up.				
	-	ated that the resident told				
		piercing and was Hispanic.				
		ephone interview on 1/15/14				
	at 2:01 PM that on 1/5/14 at approximately 7:30 AM she went in and asked Resident #2 if she was					
		eakfast. The NA stated that				
		it was the middle of the night				
		care. The NA stated that she				
		urned with NA #2 and the				
	9	et up so they left the room.				
		e and NA #2 returned after				
	•	e resident up. The NA stated				
		the nurse that someone tated that she did not kick				
		stated that she did not				
		esident any more that day.				
		AM a written statement was				
		inistrator that stated NA #1				
	had worked on the da 1/1/14 and day shift of	ay and evening shifts on on 1/2/14.				
	On 1/16/14 at 2:40 P	M Resident #2 was				
		n with two visitors. The				
		her husband and the other				
	-	mber. An attempt was made				
		sident about the incident on ent ' s family encouraged her				
		dent. The Resident stated: "				
		discussed and that 's it. "				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	<i>I</i> APPROVED 0938-0391	
-	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		345373	B. WING				C 17/2014	
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
OCEAN TI	RAIL HEALTHCARE & RI	EHAB CENTER		630 FODALE AVENUE SOUTHPORT, NC 28461				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
F 223	Continued From page	2 11	F	223	3			
	stated in an interview she interviewed Resid again on 1/15/14 at 10 (SW) stated that the r not report prior incide 1/5/14 was the first in The SW stated that R eyes when she told h cause a problem beca until she died and she be punished. The SW her that the incident of incident and she was SW stated that Resid kicked her and the resid kicked her and the resid solutional kick that 3a. Resident #1 was a 5/1/13 and had diagn (Chronic Obstructive	scared out of her skin. The ent #2 reported that NA #1 sident described the kick as it just brushed her. admitted to the facility on oses that included COPD Pulmonary Disease), ase, Congestive Heart						
	The Care Area Assessment (CAA) for Cognitive Status and Communication dated 5/13/13 revealed that the resident was unable to be oriented due to progressive cognitive decline. The CAA revealed that the resident was alert to self but confused to time and place and unable to verbalize needs and concerns secondary to vascular dementia. The CAA revealed that the resident was resistive to care, hitting, kicking and cursing at staff. The Quarterly Minimum Data Set (MDS) Assessment dated 11/1/13 revealed that the resident had short and long term memory							

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345373	B. WING				C 17/2014
NAME OF P	ROVIDER OR SUPPLIER		•	ę	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
OCEAN T	RAIL HEALTHCARE & RI	EHAB CENTER			630 FODALE AVENUE SOUTHPORT, NC 28461		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 223	The MDS revealed the dependent on staff for The MDS revealed the behaviors during the The Care Plan dated that the resident was kicking and cursing. A to check the resident needs and address to anxiety or resistive be needed. The Director of Nursin interview on 1/14/14 a her that NA #1 told Re he fell out of the whee NA (nursing assistant on 1/15/14 at 12:55 P push Resident #1 to t geri-chair. The NA sta trying to scoot out of t The NA stated she he resident: " I hope you can send you to the h that this happened in 2013. The NA stated to the residents and s was not the kind of wo On 1/15/14 at 2:01 Pt telephone interview tf #1 that she hoped he to go to the hospital. 3b. Resident #1 was a	verely cognitively impaired. e resident was totally r all activities of daily living. at the resident had no 7 day assessment period. 5/13/13 included a problem resistive to care by hitting, among the approaches was frequently for anticipated or reduce risks for agitation, shaviors and redirect as ng (DON) stated in an at 1:15 PM it was reported to esident #1 that she hoped elchair) #3 stated in an interview M that she observed NA #1 he dining room in his ited that the resident was he chair like he always did. eard NA #1 say to the i fall out of the chair so they ospital. " The NA stated August or September of that NA #1 talked very nasty he had told the NA that this ork for her.	F	223	3		

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 02/17/2014 MAPPROVED O. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		345373	B. WING			01	C / 17/2014
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
OCEAN T	RAIL HEALTHCARE & R	EHAB CENTER			30 FODALE AVENUE SOUTHPORT, NC 28461		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	I IX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 223	(Chronic Obstructive Coronary Artery Dise Failure and Advanced The Care Area Assess Status and Communi revealed that the resi oriented due to progr CAA revealed that the but confused to time verbalize needs and over vascular dementia. T resident was resistive cursing at staff. The Quarterly Minimu Assessment dated 11 had short and long te was severely cognitiv revealed that the resi on staff for all activitie revealed that the resi during the 7 day asse The Care Plan dated that the resident was kicking and cursing. A to check the resident needs and address to anxiety or resistive be needed. NA (nursing assistant on 1/14/14 at 1:50 PM Resident #1 ' s room thumping the residen that this happened av specific about a date.	Pulmonary Disease), ase, Congestive Heart d Dementia. ssment (CAA) for Cognitive cation dated 5/13/13 dent was unable to be essive cognitive decline. The e resident was alert to self and place and unable to concerns secondary to he CAA revealed that the e to care, hitting, kicking and um Data Set (MDS) 1/1/13 revealed the resident rm memory problems and rely impaired. The MDS dent was totally dependent es of daily living. The MDS dent had no behaviors essment period. 5/13/13 included a problem resistive to care by hitting, Among the approaches was frequently for anticipated o reduce risks for agitation, ehaviors and redirect as	F	223			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345373	B. WING				C 17/2014
NAME OF P	ROVIDER OR SUPPLIER		ł	S	TREET ADDRESS, CITY, STATE, ZIP CODE	·	
OCEAN T	RAIL HEALTHCARE & RI	EHAB CENTER			30 FODALE AVENUE OUTHPORT, NC 28461		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 223	to tell the resident that the wheelchair and ha (August/September 2 The Administrator sta 1/14/14 at 3:45 PM th allegation that NA #1 head. The Administra considered thumping be abuse. On 1/15/14 at 2:01 PM interview that she new the head. The Administrator was Jeopardy on 1/16/14 at provided a credible al 1/17/14 at 1:55 PM. T indicated: For Resident #1, the funaware of allegation Resident #1. The DO report the allegation to undetermined when the place. The resident is 24-hour report has be 5-day will be complete NA #1 was terminated The DON has react the administrator and consultant for failing to abuse to the administ retrained by the direct corporate nurse consultant	tt she hoped he fell out of ad to go to the hospital 013). ted in an interview on hat she was not aware of the thumped Resident #1 on the tor stated that she the resident on the head to W, NA #1 stated in an ver thumped Resident #1 on s notified of the Immediate at 10:00 AM. The facility legation of compliance on The allegation of compliance facility Administrator was #1 against NA #1 to N was aware and failed to o the administrator. It is he alleged incident took deceased (11/4/13). A sen completed 1/17/14. A ed by 1/21/14. The accused d 1/16/14. ceived disciplinary action by the corporate nurse o report an allegation of	F	223			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	<i>I</i> APPROVED 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		LE CONSTRUCTION	(X3) DATE	
		345373	B. WING				C 17/2014
NAME OF PI	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
OCEAN TI	RAIL HEALTHCARE & RI	EHAB CENTER		630 FODALE AVENUE SOUTHPORT, NC 28461			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 223	Continued From page	9 15	F	223	3		
	For the second allega notified on 1/16/14 by Resident #1. The C.N. clearly report to the n the employee respons It is undetermined wh place. The resident is A 24-hour report has 5-day will be complete The accused NA #1 w The C.N.A. has r by the DON and an in with concentration on all allegations. The Nurse has re the DON and an insel with concentration on all allegations. For Resident #2, rem NA #1 was suspende investigation. An inve was completed 1/9/14 work 1/10/14 after con but not to the care an NA #1 was suspende subsequently termina A 24-hour and 5-day in 1/15/14. The Administrato action from the directed initiate and complete reports on allegations retrained by the direct	ation, the Administrator was of surveyor concerning I.A. was aware and failed to urse the alleged abuse and sible. en the alleged incident took deceased (11/4/13). been completed 1/17/14. A ed by 1/21/14. vas terminated 1/16/14. eccived disciplinary action aservice on the abuse policy requirements for reporting eccived disciplinary action by tryice on the abuse policy requirements for reporting ains in the facility. d 1/6/14 pending stigation of the allegation 4. NA #1 was returned to mpletion of the investigation d service of Resident #2. d again 1/13/14 and ted 1/16/14. report was completed or has received disciplinary or of operations for failing to the 24-hour and 5-day 5. The Administrator was tor of operations and the					
	retrained by the direct						

Facility ID: 923382

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT OF DEF AND PLAN OF CORF	ICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345373	B. WING				C 17/2014
NAME OF PROVID	ER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		-
OCEAN TRAIL	HEALTHCARE & RE	HAB CENTER			330 FODALE AVENUE SOUTHPORT, NC 28461		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
with all a the con abu retra corp with all a For 1/9/ inve was #1 v of th of # Ress On NA : sub A 2/ 1/15 actii initia repor retra corp with all a	The DON has rec administrator and sultant for failing to se to the administr ained by the direct porate nurse consu- concentration on allegations. Resident #8, an ir 14. NA #1 was sus estigation. An inves- se completed 1/9/14 was returned to wo he investigation bu 2. sident #3 was discl 1/13/14 the reside #1 was suspended sequently terminal 4-hour and 5-day r 5/14. The Administrator on from the director ate and complete for the or allegations ained by the director of concentration on allegations. those residents ha cted by the same	requirements for reporting ceived disciplinary action by the corporate nurse or report an allegation of rator. The DON was or of operations and the ultant on the abuse policy requirements for reporting nvestigation was completed spended 1/6/14 pending stigation of the allegation or pending investigation. NA ork 1/10/14 after completion it not to the care and service harged 1/7/14. Int deceased in the hospital. d again 1/13/14 and	F	223			

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		LE CONSTRUCTION	(X3) DATE		
			A. DOILDI			С		
		345373	B. WING			01/	17/2014	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
					630 FODALE AVENUE			
OCEAN T	RAIL HEALTHCARE & RI	EHAB CENTER			SOUTHPORT, NC 28461			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE	
F 223	capable of being inter mistreated by a staff r residents interviewed by any member of the . The residents of Council meeting on T The residents were re- free from abuse, diffe and who to report it to . The administrativ re-educated on the fa Procedure by the Cor . All facility employ the facility 's Abuse F Administrator and Dir mandated to attend th Procedure inservice of 11:30 AM, 90% of all inserviced on the abu not be allowed to wor inserviced. . The Social Worke parties of residents un themselves to inquire in resident behavior the abuse. . The nursing staff for injuries of unknow to speak for themselv . Employees who abuse and failed to re- disciplinary action. . The Administrato action from the Direct to initiate and comple reports on allegations retrained by the Direct Corporate Nurse Con	viewed if they had ever felt member of the facility. All denied feeling mistreated e staff. the facility had a Resident hursday, January 16, 2014. eminded of their right to be rent types of abuse and how o. re staff have been cility ' s Abuse Policy and porate Nurse Consultant. rees will be re-educated on Policy and Procedure by the ector of Nursing and will be ne Abuse Policy and quarterly. On 1/17/14 at employees had been se policy. Employees will k until they have been er contacted all responsible nable to speak for of any concerns or changes nat could indicate possible has completed a skin check n origin of residents unable es. reportedly knew of resident	F	223	3			

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/17/201 FORM APPROVE OMB NO. 0938-039
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345373	B. WING _		C 01/17/2014
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE
	AIL HEALTHCARE & R			630 FODALE AVENUE	
UCEAN II		ERAD CENTER		SOUTHPORT, NC 28461	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 223 F 225 SS=J	the administrator and Consultant for failing abuse to the administ retrained by the Direc Corporate Nurse Com with concentration on all allegations. On 1/17/14 at 3:00 Pl validated by random is that the staff had rece facility 's abuse polic Interviews revealed th knowledgeable about the different kinds of a understanding they w abuse immediately to 483.13(c)(1)(ii)-(iii), (c INVESTIGATE/REPC ALLEGATIONS/INDIV The facility must not e been found guilty of a mistreating residents had a finding entered registry concerning al of residents or misap and report any knowle court of law against a indicate unfitness for	ceived disciplinary action by the Corporate Nurse to report an allegation of trator. The DON was ctor of Operations and the asultant on the abuse policy requirements for reporting M the credible allegation was interviews with staff showing eived inservices on the ies and procedures. the definition of abuse and abuse. The staff voiced vere to report instances of their nurse or supervisor. c)(2) - (4) DRT	F 2	23	ису)
	or licensing authoritie The facility must ensu involving mistreatmer including injuries of u	ure that all alleged violations nt, neglect, or abuse,			

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FC	ED: 02/17/2014 RM APPROVED NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	TIPLE CONSTRUCTION	(X3) DA	ATE SURVEY DMPLETED
		345373	B. WING			C 01/17/2014
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STA		
OCEAN T	RAIL HEALTHCARE & R	EHAB CENTER		630 FODALE AVENUE SOUTHPORT, NC 28461		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETION DATE
F 225	immediately to the ad to other officials in ac through established p State survey and cert The facility must have violations are thoroug prevent further potent investigation is in pro The results of all inve to the administrator o representative and to with State law (includ certification agency) v incident, and if the all	esident property are reported Iministrator of the facility and cordance with State law procedures (including to the ification agency). e evidence that all alleged yhly investigated, and must tial abuse while the gress.	F	225		
	by: Based on record revi interviews, the facility day reports with the H Registry for allegation #8, Resident #2 and I residents reviewed fo Nursing failed to notif alleged verbal abuse sampled residents an complete a thorough abuse. Facility staff fa to the Administrator fo sampled residents wh not being protected fr	is not met as evidenced iew and staff and resident failed to file 24 hour and 5 dealth Care Personnel ns of abuse for 3 (Resident Resident #1) of 4 sampled ir abuse. The Director of for 1 (Resident #1) of 4 do the facility failed to investigation of the alleged ailed to report physical abuse for 1 (Resident #1) of 4 nich resulted in the resident for 1 (Resident #1) of 4			ion is a necessary cipate in the Medicare am(s) and does not, in ute an admission to eged deficient at the hospital on s unrelated to the	

Event ID: K3Q011

Facility ID: 923382

If continuation sheet Page 20 of 54

		MEDICAID SERVICES				0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE S COMPLI	
					С	
		345373	B. WING		01/1	7/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE	
OCEAN T	RAIL HEALTHCARE & R	EHAB CENTER		630 FODALE AVENUE SOUTHPORT, NC 28461		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE	(X5) COMPLETIO DATE
F 225	Continued From page	e 20	F 22	25		
	The findings included	i:		abuse was made to the a 01/03/14. The incident is	s alleged to have	
	Immediate leonardu	began on 1/1/14 and was		occurred on 01/01/14. T was notified of the allega		
		at 10:00 AM. Immediate		Resident #8 by the ADO		
	Jeopardy was removed on 1/17/14 at 1:55 PM			NA #1⊡s employment w		
		ided a credible allegation of		01/06/14 pending an inv	estigation of the	
	compliance. The facil			allegations related to Re		
		be and severity of D (no		Administrator conducted		
		ential for more than minimal ediate jeopardy) to complete		into the allegations invol The Administrator, based		
		100% of the staff and for the		accounts, resident and s		
	facility to implement t			concluded the investigat		
	corrective action.			and could not substantia		
				NA#1 returned to work o		
	1. Resident #8 was a	idmitted to the facility on		did not return to the care	and services of	
		noses that included Chronic		Resident #8. The Admir		
		ry Disease, Alzheimer ' s		completed a 24-Hour an	, e	
	Disease and Depress	SION.		Report specific to the all		
	Poviow of the facility	's investigation file revealed		NA#1 and Resident #8 c reports were submitted t		
) Aide #1 reported in writing		Carolina Healthcare Per		
		ent #8 rang her call light and		(NCHCPR) on 01/15/14.		
		ad spilled her soda and ice		employment was termina		
		ore. The Med Aide 's written				
		hat the Med Aide observed				
		the resident in an intimidating		Currently, Resident #2 re		
		esident that when she rang		and free from any and a		
	-	ded to tell her everything she d to stay off her call light.		verbal abuse. On 01/05 reported having been mi		
	-	led that the resident was		unnamed staff member t	-	
		nrowing her hands in front of		Resident #2 described th		
		way and was yelling: " Get		to Med Aide #2. Med Aid		
	out of my face. " The	e Statement revealed the		allegation to the ADON of	on 01/05/14.	
	-	t to the Assistant Director of		Pursuant to the facility		
	-	not a 24-hour or 5-day report		the accused staff member		
	in the file.			re-assigned to non-resid		
		ated in an interview on		the laundry on 01/05/14.		
	I THE AUTHINISTRATOR STR			began an investigation of	1101/03/14. THE	

Facility ID: 923382

If continuation sheet Page 21 of 54

						10.0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			. ,	TE SURVEY MPLETED
			A. BUILDING	G		С
		345373	B. WING			1/17/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI		1/1//2014
				630 FODALE AVENUE	TOODE	
OCEAN T	RAIL HEALTHCARE & R	EHAB CENTER		SOUTHPORT, NC 28461		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN	OF CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE / CROSS-REFERENCED T DEFICIE	O THE APPROPRIATE	COMPLETION DATE
F 225	Continued From page	e 21	F 22	25		
		that she did not do a 24-hour		Administrator suspended	d NA #1⊓s	
		use the resident denied that		employment 01/06/14, b		
	the incident occurred			allegations related to Re		
				Administrator □s receipt,	on 01/06/14, of	
		M the Administrator stated in		an additional allegation i	-	
		did not know she had to file		#8 and NA#1. The Admi		
		y report to the state unless		conducted an investigati		
	the abuse was substa	antiated.		allegations involving Res 8. Resident #2 was inte		
	2 Resident #2 was a	dmitted to the facility on		the ADON, and Social W	2	
	5/14/13 and had diag	-		the allegations involving		
		e, Dementia with Lewey		#2⊡s accounts of both th		
	Bodies, Stroke and D	-		the description of the ac	-	
		-		one interview to the next	t. The	
	-	lurse #1 dated 1/5/14 at 7:50		Administrator, based on	written accounts,	
		the 7AM-3PM shift on the		resident and staff intervi		
	-) pass, Resident #2 reported		the investigation on 01/0		
		NA (nursing assistant) was		not substantiate the alle		
		e with her and that she was ety. The note revealed the		either of the identified re		
		is the Assistant Director of		Subsequent to the Admi investigation, NA#1 retu		
	Nursing (ADON) was			01/10/14, but did not ret		
		nounou.		and services of Residen		
	A Nurse 's Note by N	lurse #1 dated 1/5/14 at		Administrator completed		
		nat upon the last med pass,		5-Day Working Report s		
		voicing concern for her		allegations involving NA		
		just so scared because she		# s 2 and 8 on 01/15/20		
	is so big and all I can	do is yell. "		the reports to the North		
				Healthcare Personnel R		
		tion file included written		on 01/15/14. NA #1 s e		
		/14 by Nurse #1 and Med I Resident #2 alleged NA #1		terminated on 01/16/14. Social Worker shall prov		
	had kicked her and h			reassurance on a weekly		
		r during care that morning.		and monthly x 3 months		
		le a 24 hour or 5 day report		to ensure the resident fe		
		the allegation of abuse.		from abuse. Resident #2		
		-		by a psychological servi	-	
		ited in an interview on		basis, as ordered prior to		
	1/17/14 at 10:45 AM	she thought the 24 hour and		incident, for psychothera	apy and will	

Facility ID: 923382

If continuation sheet Page 22 of 54

		MEDICAID SERVICES				IO. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION G		TE SURVEY MPLETED
			7. DOILDIN			С
		345373	B. WING		0	1/17/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	RAIL HEALTHCARE & F			630 FODALE AVENUE		
				SOUTHPORT, NC 28461		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 225	Continued From pag	e 22	F 2	25		
	5 day reports only ha the abuse allegation	ad to be filed with the state if was substantiated.		continue as ordered by her att physician and psychotherapis	0	
	5/1/13 with diagnose	admitted to the facility on that included Chronic ary Disease, Congestive		Resident #1 expired on 11/04/ reasons unrelated to the alleg in F223. a)The DON states it v reported to her by an NA, but	ations cited was	
	On 1/14/14 at 1:15 F (DON) stated in an ir	M the Director of Nursing nterview she had a report that		recall which NA, that the NA o NA#1 tell resident #1 that she fell out of the wheelchair. The	verheard hoped he DON was	
	of the wheelchair. Th back in the summer,	It that she hoped he fell out ne DON stated this happened maybe August or September tated she did not report this		also told there were two family present. According to the DON with those two family member	l, she spoke s who both	
	to the Administrator.	ated in an interview on		denied hearing any such state anyone to any resident during The DON did not report this al the Administrator. (b) At no tin	their visit. legation to	
	1/14/14 at 3:45 PM s allegation that NA #1	told Resident #1 that she		make specific allegation(s) of related to Resident #1 or NA#	abuse 1 to Nurse	
	hospital until yesterd	he chair and had to go to the ay when the social worker Services came in and told		 #3. Rather, NA#2 asked Nurs general, nonspecific resident/e questions related to abuse. A 	employee	
	her the allegation wa			in the 2567, Nurse #3 instructor appropriately to report any sus	ed NA#2	
	PM that she observe	aterview on 1/15/14 at 12:55 of NA #1 roll Resident #1 to		abuse. NA#2 failed to report a allegations of abuse specific to	NA#1 or	
	say to the resident:	s geri-chair and heard NA #1 " I hope you fall out of the id you to the hospital. " NA		Resident #1. Based on the ir contained in the 2567 and bas interviews, the alleged inciden	ed on staff	
	#3 stated she reporte weekend supervisor	ed the incident to the and wrote a statement about		at an undetermined time and o time, has Adult Protective Ser	date. At no vices	
	longer worked at the	stated that the supervisor no facility. There was not a ort filed as there was no		conducted an investigation sp Resident #1. At no time, was t aware of allegation #2, as ider	he DON	
	investigation.			2567. The Administrator com investigation, and filed a 24-H	oleted an our Report	
	5/1/13 with diagnose	admitted to the facility on s that included Chronic ary Disease, Congestive		01/17/14 and 5-Working Day I the NCHCPR on 01/22/14.	Report with	

Facility ID: 923382

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						10.0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		· · ·	TE SURVEY MPLETED
			A. BUILDING	3		С
		345373	B. WING			1/17/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		1/1//2014
				630 FODALE AVENUE	-	
OCEAN T	RAIL HEALTHCARE & R	EHAB CENTER		SOUTHPORT, NC 28461		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETION DATE
F 225	Continued From page	e 23	F 22	25		
	Heart Failure and Adv					
		-		For those residents having the	e potential to	
	NA #2 stated in an in	terview on 1/14/14 at 1:50		be affected by the same allege		
		n Resident #1 ' s room and		practice(s):		
		nping the resident on the				
		stated she reported this to		1. The Administrator, Directo		
	Nurse #3. The NA sta			Nursing, and all other adminis were in-serviced on the facility		
	statement regarding t	incident or asked to write a		Policy, including any reporting		
	Statement regarding			requirements, by the Director		
	Nurse #3 stated in ar	n interview on 1/14/14 at 2:55		Operations and Corporate Nu		
	PM that NA #2 asked	I her what she should do if		Consultant on 01/16/14.		
	she saw someone be	eing thumped on the head				
	but did not say who w	vas involved in the incident.		2. All staff, including direct a	nd indirect	
		e told the NA to report it to		care staff, was required to rec		
		e stated that shortly after, NA		education on the facility s Ab	-	
		o she thought the NA had		and the importance of reportin	g	
		to her nurse. NA #2 was		allegations of abuse, neglect,	n of	
		rview and stated she thought dent to Nurse #3. The NA		mistreatment, misappropriatio property and/or injuries of unk		
		e #3 she saw someone		No employee was allowed to v	-	
		on the head. The NA stated		completing the referenced trai		
		nyone else. Nurse #3 stated		newly hired staff, such educat		
	she did not report wh	at she was told about the		included in the staff⊡s genera		
	incident to anyone ar	nd thought that NA #2 told		prior to the staff s beginning		
	her nurse.			staff will be required to attend		
		•••• ••••		in-service related to the facility	abuse and	
		M the Administrator stated in		neglect policy quarterly.		
		was not aware of the ent #1 was thumped on the		3. The Director of Operation	s shall	
		when the social worker from		monitor the facility s Grievan		
		vices came in and told her		monthly for three months to er		
		ing investigated. The		are no grievances demonstrat		
	Administrator stated			suspicions of abuse, neglect,		
	thumping a resident of	on the head to be abuse and		mistreatment, misappropriatio	n of resident	
		e reported what she was		property and/or injuries of unk		
		or stated that if the incident		which the facility has not repo		
	-	he would have attempted to		pursuant to the facility s Abus		
	get a statement from	NA #2. There was not a		Similarly, the Director of Operation	ations shall	

Facility ID: 923382

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		ND HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 02/17/201 RM APPROVE O. 0938-039
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345373	B. WING			0	C I/17/2014
NAME OF PR	ROVIDER OR SUPPLIER	•		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
				63	30 FODALE AVENUE		
OCEAN II	RAIL HEALTHCARE & R	EHAB CENTER		S	OUTHPORT, NC 28461		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	Continued From page	e 24	F 2	225			
	24-hour or 5-day reportion of the administrator and the resident or the N/know what to report. In the resident or the N/know what to report. In the Administrator was Jeopardy on 1/16/14 provided a credible a 1/17/14 at 1:55 PM. The indicated: For Resident #1, the unaware of allegation the allegation to the the to report the allegation to the the termined when the place. The resident is 24-hour report has be 5-day will be completed to the administrator and consultant for failing the abuse to the administrator and consultant for failing the allegations. For the second allegations.	ort done as the Administrator allegation. AM Nurse #3 stated in an did not tell her the name of A involved and she did not The Nurse stated that it did port what she had heard being thumped on the head. As notified of the Immediate at 10:00 AM. The facility llegation of compliance on The allegation of compliance facility Administrator was a #1 against NA #1 to N was aware and failed to to the administrator. It is the alleged incident took a deceased (11/4/13). A een completed 1/17/14. A ted by 1/21/14. The accused d 1/16/14. ceived disciplinary action by I the corporate nurse to report an allegation of trator. The DON was ctor of operations and the sultant on the abuse policy a requirements for reporting			review the facility s incident reports monthly for three months to ensure the are no reported incidents which may indicative of abuse, neglect, mistreat misappropriation of resident property and/or injuries of unknown origin whit the facility has not reported pursuant the facility s Abuse Policy. The Administrator shall review any and al reports of abuse, neglect, mistreatmen misappropration of resident property and/or injuries of unknown origin with Director of Operations to ensure the investigation and reporting is consisted with the facility s Abuse Policy. Evice of monitoring by the Director of Operations shall be certified by signa of the monitoring tool monthly. Identi discrepancies shall be remediated ar reported pursuant to the facility s At Policy. The Plan of Correction for this allege deficient practice(s) has been incorporated into the facility s most recent Quality Assurance Committee meeting minutes and shall be evalua for effectiveness no less than monthl three months and quarterly thereafte	be ment, ch to l ent, o the ent dence ture fied nd ouse d ted y for	
	notified on 1/16/14 by Resident #1. The C.N	y surveyor concerning J.A. was aware and failed to surse the alleged abuse and					

If continuation sheet Page 25 of 54

	-					FORI	M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •			(X3) DATE COMF	E SURVEY PLETED
		345373	B. WING				C / 17/2014
NAME OF P	SPOR MEDICARE & MEDICAID SERVICES Dependencies (x1) PROVIDERSUPPLIENCLIA 345373 A. BUILDING 345373 B. WINO CONDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 630 FODALE AVENUE STREET ADDRESS, CITY, STATE, ZIP CODE 630 FODALE AVENUE STREET ADDRESS, CITY, STATE, ZIP CODE 640 FOR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 640 FOR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 650 FODALE AVENUE SUTHPORT, NC 28461 SUMMARY STATEMENT OF DEFICIENCES ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG Continued From page 25 F225 the employee responsible. F 225 Continued From page 25 F 225 the accused NA #1 was terminated 1/16/14. F 225 - The C.N.A. has received disciplinary action by the DON and an inservice on the abuse policy with concentration on requirements for reporting all allegations. F 225 For Resident #2, remains in the facility. N #1 was suspended 1/6/14 pending investigation. An investigation of the allegation was completed 1/6/14, N #1 was returned to work 1/10/14 after completion of the investigation but not to the care and service of Resident #2. N #1 was suspended again 1/13/14 and subsequentor was retrained by the director of operati		•				
OCEAN T	AN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 345373 B. WING COF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE S0 FODALE AVENUE SOUTHPORT, NC 28461 DID CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX 225 Continued From page 25 the employee responsible. It is undetermined when the alleged incident took place. The resident is deceased (11/4/13). A 24-hour report has been completed 1/17/14. A 5-day will be completed by 1/21/14. The accused NA #1 was terminated 1/16/14. F 225 • The Nurse has received disciplinary action by the DON and an inservice on the abuse policy with concentration on requirements for reporting all allegations. F or Resident #2, remains in the facility. NA #1 was suspended 1/6/14 pending investigation. An investigation of the allegation was completed 1/9/14. NA #1 was returned to work 1/10/14 after completion of the investigation by the to to the care and service of Resident #2. NA #1 was suspended again 1/13/14 and subsequently terminated 1/16/14. A 24-hour and 5-day report was completed 1/15/14.						
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE
F 225	the employee respons It is undetermined wh place. The resident is A 24-hour report has 5-day will be complete The accused NA #1 v • The C.N.A. has r by the DON and an irr with concentration on all allegations. • The Nurse has re- the DON and an inser- with concentration on all allegations. For Resident #2, rem NA #1 was suspende investigation. An inve- was completed 1/9/14 work 1/10/14 after con- but not to the care an NA #1 was suspende subsequently termina A 24-hour and 5-day 1 1/15/14. • The Administrato action from the direct initiate and complete reports on allegations retrained by the direc corporate nurse cons with concentration on all allegations.	sible. en the alleged incident took a deceased (11/4/13). been completed 1/17/14. A ed by 1/21/14. vas terminated 1/16/14. received disciplinary action aservice on the abuse policy requirements for reporting eceived disciplinary action by rvice on the abuse policy requirements for reporting ains in the facility. d 1/6/14 pending stigation of the allegation 4. NA #1 was returned to mpletion of the investigation d service of Resident #2. d again 1/13/14 and ted 1/16/14. report was completed or has received disciplinary or of operations for failing to the 24-hour and 5-day 5. The Administrator was tor of operations and the ultant on the abuse policy requirements for reporting	F	225	5		

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	-	ID HUMAN SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			
		345373	CAID SERVICES ROVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER: 345373 B. WING 345373 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 630 FODALE AVENUE SOUTHPORT, NC. 28461 TO F DEFICIENCIES BE PRECEDED BY FULL PREFIX TAG PREFIX CROSS-REFERENCED TO THE APPROPRIUD B DEFICIENCY F 225 Int an allegation of The DON was Operations and the on the abuse policy rements for reporting gation was completed ed 1/6/14 pending on of the allegation ing investigation. NA 0/14 after completion o the care and service d 1/7/14. seased in the hospital. n 1/13/14 and 16/14. was completed on received disciplinary perations for failing to -hour and 5-day			C 17/2014	
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
OCEAN T	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE OCEAN TRAIL HEALTHCARE & REHAB CENTER 630 FODALE AVENUE SUUTHPORT, NC 28461 SUUTHPORT, NC 28461 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTIVE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROF						
				5			
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI	х	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		(X5) COMPLETION DATE
F 225	Continued From page	26	E E	225			
	-	-					
		requirements for reporting					
	all allegations.						
	-						
		•					
	-	it not to the care and service					
	Resident #3 was disc	-					
		•					
	-	-					
	-	report was completed on					
	1/15/14.						
		b. The administrator was					
		tor of operations and the					
	-	ultant on the abuse policy requirements for reporting					
	all allegations.						
	For those residents h	aving the potential to be					
		alleged deficient practice:					
	• The Social Work	er asked all residents					
		rviewed if they had ever felt					
	-	member of the facility. All denied feeling mistreated					
	by any member of the	-					
	The residents of	the facility had a Resident					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	TIPI	E CONSTRUCTION	(X3) DATE	
	CORRECTION	IDENTIFICATION NUMBER:					PLETED
				NO .			c
		345373	B. WING			C 01/17/2014	
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 01/	17/2014
					630 FODALE AVENUE		
OCEAN T	RAIL HEALTHCARE & RI	EHAB CENTER			SOUTHPORT, NC 28461		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	3E	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	DATE
F 225	Continued From page	e 27	F	225	5		
	Council meeting on T	hursday, January 16, 2014.					
	The residents were re	eminded of their right to be					
		rent types of abuse and how					
	and who to report it to						
		ve staff have been					
		icility 's Abuse Policy and					
	-	porate Nurse Consultant. yees will be re-educated on					
		Policy and Procedure by the					
	-	ector of Nursing and will be					
	mandated to attend th	-					
		quarterly. On 1/17/14 at					
	11:30 AM, 90% of all						
		ise policy. Employees will					
		k until they have been					
	inserviced.						
	 The Social Work 	er contacted all responsible					
	parties of residents u	nable to speak for					
	-	of any concerns or changes hat could indicate possible					
	abuse.						
	 The nursing staff 	has completed a skin check					
	-	n origin of residents unable					
	to speak for themselv	ves.					
	 Employees who 	reportedly knew of resident					
	abuse and failed to re	eport have received					
	disciplinary action.						
		or has received disciplinary					
		tor of Operations for failing					
		te the 24-hour and 5-day					
		5. The Administrator was					
	-	ctor of Operations and the					
	-	sultant on the abuse policy					
		requirements for reporting					
	all allegations.	asived dissiplinant action by					
		ceived disciplinary action by					
	the administrator and	to report an allegation of					
	abuse to the administ						

If continuation sheet Page 28 of 54

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345373	B. WING				C / 17/2014
NAME OF P	ROVIDER OR SUPPLIER	I		5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
OCEAN T	RAIL HEALTHCARE & R	EHAB CENTER	630 FODALE AVENUE SOUTHPORT, NC 28461				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 225 F 226 SS=J	Corporate Nurse Con with concentration on all allegations. On 1/17/14 at 3:00 Pl validated by random that the staff had rece facility 's abuse polic Interviews revealed th knowledgeable about the different kinds of understanding they w abuse immediately to 483.13(c) DEVELOP/ ABUSE/NEGLECT, E The facility must deve policies and procedur	tor of Operations and the sultant on the abuse policy requirements for reporting M the credible allegation was interviews with staff showing eived inservices on the ies and procedures. the definition of abuse and abuse. The staff voiced vere to report instances of their nurse or supervisor. /IMPLMENT ETC POLICIES elop and implement written res that prohibit t, and abuse of residents		225			1/20/14
	by: Based on policy and resident interviews, th their abuse policies a to protect 1 (Resident from verbal abuse by allegation of abuse to hours and failing to re verbal abuse. 2. Faile of 4 sampled resident abuse by not suspend	the administrator within 24 eport other instances of ed to protect 1 (Resident #2) ts from verbal and physical ding the staff member e. 3. Failed to protect 1			F226 Standard Disclaimer: This Plan of Correction is a necessary requirement to participate in the Medic and Medicaid program(s) and does not any manner, constitute an admission to the validity of the alleged deficient practice(s). Standard Disclaimer: F226	t, in	

Facility ID: 923382

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	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION		NO. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:			· · · ·	OMPLETED
			A. BOILDING			С
		345373	B. WING			01/17/2014
NAME OF PI	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CO		•
				630 FODALE AVENUE		
OCEAN II	RAIL HEALTHCARE & R	EHAB CENTER		SOUTHPORT, NC 28461		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE
F 226	Continued From page	e 29	F 22	6		
		buse by failing to report		Resident #8 expired at the h	ospital on	
		to the administrator and		01/13/14 for reasons unrelat		
	•	orough investigation of the		allegations cited in F223. A		
	alleged abuse.			abuse was made to the ADC		
				01/03/14. The incident is all	-	
	The findings included			occurred on 01/01/14. The		
	Immodiate Joonardy	began on 1/1/14 and was		was notified of the allegation Resident #8 by the ADON of		
		at 10:00 AM. Immediate		NA #1⊡s employment was s		
		ed on 1/17/14 at 1:55 PM		01/06/14 pending an investig		
		ided a credible allegation of		allegations related to Reside	-	
	compliance. The facil	-		Administrator conducted an	-	
		e and severity of D (no		into the allegations involving		
		ential for more than minimal ediate jeopardy) to complete		The Administrator, based on accounts, resident and staff		
		100% of the staff and for the		concluded the investigation		
	facility to implement t			and could not substantiate th		
	corrective action.	C C		NA#1 returned to work on 0 ²	•	
				did not return to the care and	d services of	
	-	policy titled Abuse and		Resident #8. The Administra		
		Procedures last revised on		completed a 24-Hour and 5-		
	-	nder Reporting read: "1. In accident or incident		Report specific to the allegat NA#1 and Resident #8 on 0		
	-	nust report such information		reports were submitted to the		
	-	upervisor and/or the facility		Carolina Healthcare Person		
		gations of abuse shall be		(NCHCPR) on 01/15/14. NA		
	reported to the Admir			employment was terminated	on 01/16/14.	
		d as " as soon as possible,				
	•	24 hours after discovery of				
	the incident. " Page 4	This facility shall initiate		Currently, Resident #2 repor	ts feeling safe	
		residents from harm during		and free from any and all ph	-	
	-	cess. 3. Employees of the		verbal abuse. On 01/05/14,	-	
	-	n accused of resident abuse		reported having been mistre		
		nonresident care duties or		unnamed staff member to M		
		for up to ten working days		Resident #2 described the s		
	reviewed by the Adm	e investigation have been		to Med Aide #2. Med Aide#2 allegation to the ADON on 0		
	reviewed by the Adm	inioudiui.		Pursuant to the facility s Ab	1/03/14.	

Event ID: K3Q011

Facility ID: 923382

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	IO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		CONSTRUCTION		E SURVEY
							С
		345373	B. WING			0	1/17/2014
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
OCEAN T	RAIL HEALTHCARE & R	EHAB CENTER			30 FODALE AVENUE OUTHPORT, NC 28461		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETIO DATE
F 226	Continued From page	e 30	F 2	26			
	1 0	dmitted to the facility on		.20	the accused staff member, NA #1, was		
		inoses that included Chronic			re-assigned to non-resident care duties		
	Obstructive Pulmona				the laundry on 01/05/14. The ADON		
		eimer 's Disease. The			began an investigation on 01/05/14. T	he	
	-	ged to the hospital on 1/7/14			Administrator suspended NA #1 s		
	where she later expir	ed.			employment 01/06/14, based on the		
					allegations related to Resident #2, and		
		ssment (CAA) for Cognitive			Administrator s receipt, on 01/06/14, o		
1		revealed that the resident			an additional allegation involving Resid	lent	
		y responsive with periods of			#8 and NA#1. The Administrator		
	-	s able to understand others known. The CAA for Visual			conducted an investigation into the	nd	
		13 revealed that the resident			allegations involving Resident # s 2 at 8. Resident #2 was interviewed by bot		
		acts and the resident 's			the ADON, and Social Worker related t		
	vision was impaired.				the allegations involving NA#1. Reside		
					#2 s accounts of both the allegation a		
	The Quarterly Minimu	um Data Set (MDS)			the description of the accused varied fr		
		3/14 revealed that the			one interview to the next. The		
	resident was cognitiv	ely intact and vision was			Administrator, based on written accour	nts,	
	highly impaired.				resident and staff interviews, conclude	d	
					the investigation on 01/08/14 and could	d	
	The Care Plan dated	10/21/13 revealed that the			not substantiate the allegations specified	c to	
		ed about her health and was			either of the identified residents.		
		tention from the staff. The			Subsequent to the Administrator s	_	
		ff to approach the resident			investigation, NA#1 returned to work of		
	warmly at all times.				01/10/14, but did not return to the care and services of Resident #□s 2 or 8. 1		
	Δ review of the facility	y ' s Grievance Log revealed			Administrator completed a 24-Hour and	-	
		that a nursing assistant			5-Day Working Report specific to the	4	
		ely to Resident #8. A written			allegations involving NA#1 and Reside	nt	
		redication) Aide #1 revealed			# s 2 and 8 on 01/15/14 and submitter		
		Resident #8 rang the call bell			the reports to the North Carolina		
	and NA #1 entered th	ne room and asked the			Healthcare Personnel Registry (NCHC	PR)	
		ident wanted. According to			on 01/15/14. NA #1⊡s employment wa		
		the Resident stated that she			terminated on 01/16/14. The facility s		
		and ice and wanted some			Social Worker shall provide Resident #		
		revealed that the NA stood			reassurance on a weekly basis x 4 wee		
		it in an intimidating way and			and monthly x 3 months and quarterly		
	responded to the resi	ident that when she rang her			to ensure the resident feels safe and fr	ee	

Facility ID: 923382

If continuation sheet Page 31 of 54

		MEDICAID SERVICES				<u>omb no</u> T	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE COMF	SURVEY PLETED
		345373	B. WING _				C / 17/2014
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
					30 FODALE AVENUE		
OCEAN T	RAIL HEALTHCARE & R	EHAB CENTER			OUTHPORT, NC 28461		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIC DATE
F 226	Continued From page	a 31	F 2	226			
		to tell her everything she		-20	from abuse. Resident #2 is being follow	hed	
		d to stay off her call light.			by a psychological service on a weekly		
	-	ed that the resident was			basis, as ordered prior to the alleged		
		rowing her hands in front of			incident, for psychotherapy and will		
	her to push the NA av	way from her.			continue as ordered by her attending		
					physician and psychotherapist.		
	· · ·	's investigation revealed a					
		s given to the ADON that NA			Resident #1 expired on 11/04/13 for		
r	#1 spoke rudely to Re				reasons unrelated to the allegations cit	ed	
		dent was reliable and had no			in F223. (a)The DON states it was reported to her by an NA, but she did n	ot	
	complaints per the so	realed that the resident was			recall which NA, that the NA overheard		
	interviewed and report			NA#1 tell resident #1 that she hoped he			
		y. A written statement by			fell out of the wheelchair. The DON wa		
		d that on 1/2/14 on second			also told there were two family member		
		g her call light and NA#1			present. According to the DON, she sp		
	was observed to ente	r the room and asked the			with those two family members who bo	th	
	resident what she wa	nted. The statement			denied hearing any such statement from		
		dent stated that she had			anyone to any resident during their visi		
		ce and wanted some more.			The DON did not report this allegation	to	
		" (Name of NA #1) stood in			the Administrator. (b) At no time, did		
		in an intimidating way, told			NA#2 make specific allegation(s) of ab		
	her when she rings he	right then and to stay off			related to Resident #1 or NA#1 to Nurs #3. Rather, NA#2 asked Nurse #3	e	
		f Resident #8 was frightened			general, non-specific resident/employe	P	
	•	hands in front of her to			questions related to abuse. As reporte		
		1 off of her yelling get out of			in the 2567, Nurse #3 instructed NA#2		
	my face. "	, ,			appropriately to report any suspicions of		
	-				abuse. NA#2 failed to report any		
		ted in an interview on ne Assistant Director of			allegations of abuse specific to NA#1 o		
		ight statements from an			Resident #1. Based on the information contained in the 2567 and based on sta		
		t #8 that occurred on 1/2/14			interviews, the alleged incident occurre		
		Resident #2 that occurred on			at an undetermined time and date. The		
		in the morning meeting on			Administrator completed an investigation		
		Administrator stated that a			and filed a 24-Hour 01/17/14 and		
		he incident with Resident #2			5-Working Day Report 01/22/14 with th	e	
		NA had kicked the resident.			NCHCPR.		
	The Administrator sta	ted that because of that					

Facility ID: 923382

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		ND HUMAN SERVICES			PRINTED: 02/17 FORM APPR	OVED
STATEMENT O	S FOR MEDICARE & F DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	OMB NO. 0938 (X3) DATE SURVEY COMPLETED	
		345373	B. WING		C 01/17/201/	Л
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	01/17/201	-
				630 FODALE AVENUE		
OCEAN TI	RAIL HEALTHCARE & R	EHAB CENTER		SOUTHPORT, NC 28461		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE COMPL	ETION
F 226	Continued From page		F 22	6		
	of the investigation.	s suspended pending results				
	On 1/14/14 at 5:40 P an interview that the Med Aide #1 who hea	M the Administrator stated in incident was reported by ard the incident while building. The Administrator		For those residents having the p be affected by the same alleged deficient practice:		
	stated that Resident a the resident had since	#8 denied the incident and		1. The Administrator, Director Nursing, and all other administra were in-serviced on the facility Policy, including any reporting	ative staff	
	1/15/14 at 11:35 AM about the incident da not recall any unusua	that she spoke with NA #1 ted 1/2/14 and the NA could al interactions with Resident		requirements, by the Director of Operations and Corporate Nurse Consultant on 01/16/14.		
	Worker stated in an in was generally alert an some forgetfulness. T that she asked the re help her get dressed way and the resident Worker stated that sh about NA #1 from oth			2. All staff, including direct and care staff, was required to receive education on the facility s Abus and the importance of reporting allegations of abuse, neglect, mistreatment, misappropriation of property and/or injuries of unknow No employee was allowed to work to work without completing the retraining. Training for all staff was completed on 01/20/14. For new	ve e Policy of own origin. ork/return eferenced s vly hired	
	2:40 PM that Resider well and knocked over the evening of 1/2/14 she went in to give th and was on her way of entered the room in r Med Aide stated that	n an interview on 1/15/14 at t #8 was unable to see very er her drink several times on . The Med Aide stated that he resident her medication out of the room and NA #1 response to the call light. The NA #1 looked irritated. The when she left the resident 's		 staff, such education shall be ind the staff s general orientation, p staff beginning work. All staff required to attend an inservice re the facility abuse and neglect po quarterly. 3. The Administrator and/or So 	prior to the will be elated to licy	
	room she went aroun courtyard to smoke. was standing in the c	ad the corner and into the The Med Aide stated that she courtyard outside the room of Id hear NA #1 yelling at the		Worker will conduct random resi interviews, with a minimum of 5 interviewable residents on a wea x 4, then a minimum of 10 of all	dent	

Facility ID: 923382

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DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					D: 02/17/2014 MAPPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	O. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		CONSTRUCTION		E SURVEY PLETED
		345373	B. WING			01	C / 17/2014
NAME OF PI	ROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE		
				630) FODALE AVENUE		
OCEAN II	RAIL HEALTHCARE & R	EHAB CENTER		SC	OUTHPORT, NC 28461		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	stated NA #1 stated: this time but next time everything you need The Med Aide stated over the resident in a resident was raising I off of me. " The Med not touch the resident 's she could not remem occurred but it was d stated that she report and the nurse told he stated that she report and the nurse told he stated that NA #1 usu shift but that day had 3PM-11PM shift as w A review of the payro that the NA worked fr and worked 7AM-3PI sheet for Med Aide # worked 3PM-11PM o In an interview with M 4:40 PM, the Med Aid the incident occurred Med Aide stated that reported the incident Nursing (ADON) and Med Aide stated that write up the incident	window. The Med Aide "I'm going to get this up e you better tell me and stay off the call light." that NA #1 was standing n intimidating way and the her arms and saying: "Get Aide stated that NA#1 did t but was raising her voice s face. The Med Aide stated ber what time the incident ark outside. The Med Aide ted the incident to Nurse #5 er to write it up. The Med Aide ually worked the 7AM-3PM stayed over and worked the rell. Il sheet for NA #1 revealed fom 7AM to 11PM on 1/1/14 M only on 1/2/14. A payroll 1 revealed that the Med Aide n 1/1/14, 1/2/14 and 1/3/14. Med Aide #1 on 1/15/14 at de stated that she thought on Thursday (1/2/14). The on Friday (1/3/14) she to the Assistant Director of was told to write it up. The she got busy and did not until Monday morning de stated that the incident	F 2	226	interviewable residents monthly x3, a quarterly x 4 for any resident concerr specific to abuse, neglect, mistreatme misappropriation of resident property and/or injuries of unknown origin. Any such findings will be reported to the Administrator immediately, and an investigation will be conducted pursu the facility S Abuse policies. The Administrator shall report all allegatio abuse, neglect, mistreatment, misappropriation of resident property and/or injuries of unknown origin usin 24-Hour and 5-Working Day Reports Such reports shall be filed timely to th NCHCPR. Residents will be reminder their right to be free of abuse and how and to whom to report any concerns. 4. For those residents unable to communicate their needs, licensed n shall conduct weekly skin assessmer and shall report any suspicions of ab neglect, mistreatment, misappropriati resident property and/or injuries of unknown origin. Such assessments is be on-going and any suspicious findin shall be reported to the Administrator and/or Director of Nursing immediate Following any such report, the Administrator shall follow the facility a policy related to the identification, investigation, and reporting of such suspicions. All allegations of abuse,	ant to ns of ng the d of w urses ts use, on of shall ngs	
	Housekeeper #1 stat at 3:00 PM that he ha Resident #8 several f	ed in an interview on 1/15/14 ad heard NA #1 yelling at times one evening. The that he heard NA #1 tell the			neglect, mistreatment, misappropriati resident property and/or injuries of unknown origin shall be reported usir 24-Hour and 5-Working Day Reports Such reports shall be filed timely to th	ng the	

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULT	IPL F	CONSTRUCTION		SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· /			1 Y	PLETED
							С
		345373	B. WING			01/	/17/2014
NAME OF P	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
	RAIL HEALTHCARE & R	EHAB CENTER		63	30 FODALE AVENUE		
				S	OUTHPORT, NC 28461		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIO DATE
F 226	Continued From page	e 34	F 2	226			
		doing the best she could,			NCHCPR.		
		d to stop bothering her. The					
		able to provide the date or			1. The Corporate Nurse Consultant		
		ne Housekeeper stated that			conduct random interviews (5 employe		
	-	incident because he was			per week) of each department s staff	to	
		and trying to complete his			include all three shifts, weekly for 4	£	
		isekeeper stated that he ave reported the incident as			weeks, monthly for three months, and 4 quarters thereafter to ensure the star		
	•	ave reported the incident as			has understanding of the abuse policy		
	resident to be verbal				related to the identification and reportin		
					of abuse, neglect, mistreatment,	5	
	Nurse #5 stated in an	n interview on 1/15/14 at 4:30			misappropriation of resident property		
		emember Med Aide #1			and/or injuries of unknown origin. Sta	ff	
		1 yelling at Resident #8.			who are unable to demonstrate the		
		t this would be verbal abuse d the on call nurse. The			required competencies shall receive	nd	
		e remembered hearing about			education related to the identification a reporting of abuse, neglect, mistreatme		
		on a different day. Med Aide			misappropriation and/or injuries of	ont,	
		the interview and stated that			unknown origin by the Corporate Nurs	е	
		Nurse #5 about the incident.			Consultant. Evidence of such intervie	WS	
	The Med Aide stated	that when she arrived at			by the Corporate Nurse Consultant sha	all	
		4) at 3:00 PM she told the			be provided to the Administrator, in a		
		o write it up. The Med Aide			written format, weekly for four weeks,		
		usy and did not write up the de stated that the ADON was			monthly for three months, and for 4 quarters thereafter. Evidence of		
		nday (1/5/14) investigating an			monitoring shall include date, staff nar	ne	
		it #2 and NA #1 and the			function, and documentation of proficie		
		aged me to write up the			(ies) related to the reporting of abuse,	,	
		de stated that she wrote up			neglect, mistreatment, misappropriatio	n of	
		he report under the ADON '			resident property and injuries of unknow	wn	
		have it on Monday (1/6/14)			origin. Any findings or suspicions of		
	morning.				abuse, neglect, mistreatment,		
	0n 1/15/14 at 4·55 D	M the Administrator stated in			misappropriation of resident property and/or injuries of unknown origin will b	۵	
		ADON thought they could			reported to the Administrator immediat		
		egation without statements			and an investigation will begin per the		
		day 1/6/14 to report the			facility s Abuse Policy.		
		sident #8 and NA #1. The					
	Administrator stated t	that Resident #8 walked to					1

Facility ID: 923382

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	· · ·	TE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	i	со	MPLETED
		345373	B. WING			C
	ROVIDER OR SUPPLIER	343373		STREET ADDRESS, CITY, STATE, ZIP COD		1/17/2014
				630 FODALE AVENUE	2	
OCEAN TI	RAIL HEALTHCARE & R	EHAB CENTER		SOUTHPORT, NC 28461		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE
F 226	Continued From page	<u>- 35</u>	F 22	6		
1 220		and talked with her and the	F 22	0		
		nything about a problem with		The Administrator shall monit	or items 2 🗆	
	NA #1.			5 above for compliance, and		
				such evidence of monitoring i	n a written	
		or of Nursing (ADON) stated		monthly monitoring report.		
		5/14 at 7:40 PM that Med was standing outside by the		The Plan of Correction for this	hanalle a	
v # N a		#8 's room and observed NA		deficient practice(s) has been	-	
		face. The ADON stated that		incorporated into the facility		
	-	this on 1/2/14 (Thursday)		recent Quality Assurance Cor		
		he was getting ready to		meeting minutes and shall be		
	-	e ADON stated she told the led to be in writing and would		for effectiveness no less than three months and quarterly th	-	
		t the next morning. The				
		ked for the statement the				
		not find one. The ADON				
		n the building on Sunday				
		another incident and did not statement and told the Med				
		ed to report the incident it				
		in writing. The ADON stated				
		ould be heard through the				
		ng. The ADON stated that on				
	one occasion she wa dining room window a	s standing outside, near the				
	conversations in the					
	2. The facility 's abus	se policy titled Abuse and				
	Neglect Policies and	Procedures last revised on				
		nder Protection read: "1.				
		ate measures to protect				
		during the investigatory es of the facility who have				
	been accused of resi					
	reassigned to nonres	-				
		for up to ten working days				
		e investigation have been				
	reviewed by the Adm		1			1

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	MENT OF HEALTH AN S FOR MEDICARE & I		FORM APPROVED OMB NO. 0938-0391				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE	
AND I LAN OI	CONTRECTION	IDENTIFICATION NOMBER.	A. BUILDI	A. BUILDING			C
		345373	B. WING				
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
OCEAN T	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 PREFI TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE		BE	(X5) COMPLETION DATE
F 226	Resident #2 was adm 5/14/13 and had diag Parkinson ' s Disease Bodies, Stroke and D The Care Area Asses Status dated 7/3/13 reverbally responsive a known and understan Activities of Daily Livin resident required assi unsafe to transfer ind The Quarterly Minimu Assessment dated 12 was severely cognitive extensive assistance transfers. The Care Plan dated Resident #2 had impate to diagnosis of Deme problem of impaired re Disease. One of the in assist with transfers a and to use the stand The nurse ' s schedul worked 7 AM to 11 Pl A Nurse ' s Note by N PM revealed that on to first medication (med) very tearfully that her	hitted to the facility on noses that included e, Dementia with Lewey ebility. sment (CAA) for Cognitive evealed the resident was nd could make her needs ad others. The CAA for ng (ADLs) revealed the istance with ADLs and was ependently. um Data Set (MDS) 2/12/13 revealed the resident ely impaired and required for bed mobility and 5/31/13 revealed that aired thought processes due ntia. The Care Plan listed a nobility due to Parkinson ' s nterventions was for staff to and ambulation as necessary up lift for transfers. e revealed that Nurse #1	F	226			
	on-call nurse who wa Nursing (ADON) was	ety. The note revealed the s the Assistant Director of notified. The note revealed are for the resident and					

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				PRINTED: 02/17/2014 FORM APPROVED OMB NO. 0938-0391
F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		(X3) DATE SURVEY COMPLETED
	345373	B. WING _		C 01/17/2014
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE
OCEAN TRAIL HEALTHCARE & REHAB CENTER			630 FODALE AVENUE SOUTHPORT, NC 28461	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE
removed reported NA Resident #2. A Nurse 's Note by N 10:30 PM revealed th Resident #2 was still safety stating: "1'm is so big and all I can revealed the nurse re the NA was not in the The facility' investigat statements dated 1/5. Aide #2 that revealed had kicked her and ha inappropriate with her The investigation repo of counseling for NA included the following violated the following standards: "3 reside Action: Suspension p offered non care but of NA #2 stated in an int PM that on 1/5/14, N/ Resident #2 out of be want to get up. NA #2 minutes later, Nurse a resident was ready to stated she did not wa she and NA #1 were resident stated she w stated when putting th her finger and had to	A from providing care for lurse #1 dated 1/5/14 at lat upon the last med pass, voicing concern for her just so scared because she do is yell. " The note assured the resident that a building. tion file included written /14 by Nurse #1 and Med Resident #2 alleged NA #1 ad been verbally r during care that morning. ort included documentation #1 dated 1/6/14 that y: " The employee has behavior and/or work rule nt complaints. Corrective ending investigation. Was employee chose to leave. " terview on 1/14/14 at 1:50 A #1 asked her to help get ed and the resident did not 2 stated that about 30 #1 told them that the o get up and the resident int to get up. NA #2 stated as leaving the room, the rould just get up. NA #2 he side rail down she injured leave the room to put ice it	F 2		
	S FOR MEDICARE & PF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER RAIL HEALTHCARE & R SUMMARY ST (EACH DEFICIENC REGULATORY OR I Continued From page removed reported NA Resident #2. A Nurse 's Note by N 10:30 PM revealed th Resident #2 was still safety stating: "1'm is so big and all I can revealed the nurse re the NA was not in the The facility' investigat statements dated 1/5 Aide #2 that revealed had kicked her and ha inappropriate with he The investigation rep- of counseling for NA included the following violated the following standards: "3 reside Action: Suspension p offered non care but o NA #2 stated in an int PM that on 1/5/14, NA Resident #2 out of be want to get up. NA #2 minutes later, Nurse a resident was ready to stated she did not was she and NA #1 were resident stated she w stated when putting th her finger and had to and left NA #1 in the	CORRECTION IDENTIFICATION NUMBER: 345373 ROVIDER OR SUPPLIER RAIL HEALTHCARE & REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 37 removed reported NA from providing care for	S FOR MEDICARE & MEDICAID SERVICES PEDEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULT A. BUILDIN 345373 ROVIDER OR SUPPLIER 345373 B. WING_ ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFID TAG Continued From page 37 removed reported NA from providing care for Resident #2. F2 A Nurse 's Note by Nurse #1 dated 1/5/14 at 10:30 PM revealed that upon the last med pass, Resident #2 was still voicing concern for her safety stating: "1' m just so scared because she is so big and all 1 can do is yell." The note revealed the nurse reassured the resident that the NA was not in the building. F2 The facility' investigation file included written statements dated 1/5/14 by Nurse #1 and Med Aide #2 that revealed Resident #2 alleged NA #1 had kicked her and had been verbally inappropriate with her during care that morning. The investigation report included documentation of counseling for NA #1 dated 1/6/14 that included the following: "The employee has violated the following behavior and/or work rule standards: "3 resident complaints. Corrective Action: Suspension pending investigation. Was offered non care but employee chose to leave. " NA #2 stated in an interview on 1/14/14 at 1:50 PM that on 1/5/14, NA #1 asked her to help get Resident #2 out of bed and the resident did not want to get up. NA #2 stated that about 30 minutes later, Nurse #1 told them that the resident stated she would just get up. NA #2 stated when putting the sider rail down she injured her finger and had to leave the room to p	S FOR MEDICARE & MEDICAID SERVICES IF DEFICIENCIES (X1) PROVIDERSUPPLIERCLIA (P2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A BUILDING 345373 B. WING CONDER OR SUPPLIER STREET ADDRESS, CITY, STATE, Z SOFODALE AVENUE SOUTHPORT, NC 28461 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MERS PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREPIX (EACH CORRECTIVE, REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 37 removed reported NA from providing care for Resident #2. F 226 A Nurse 's Note by Nurse #1 dated 1/5/14 at 10:30 PM revealed that upon the last med pass, Resident #2. F 226 A Nurse 's Note by Nurse #1 added 1/5/14 at 10:30 PM revealed that upon the last med pass, Resident #2. F 226 The facility' investigation file included written statements dated 1/5/14 by Nurse #1 and Med Aide #2 that revealed Resident #2 alleged NA #1 had kicked her and had been verbally inappropriate with her during care that morning. In interview on 1/14/14 th1 included the following: "The employee has violated the following: "The employee has violated the following investigation. Was offered non care but employee chose to leave." IN A#2 stated in an interview on 1/14/14 at 1:50 PM that on 1/5/14, NA #1 asked her to help get Resident #2 out of bed and the resident did not want to get up. NA #2 stated that about 30 minutes later, Nurse #1 told them that the resident was need to get up and the resident stated she did not want to get up. IN A#2 stated as she and NA #1 were leaving the room, the resident was th

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	CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA				OMB NO. 0938-039 (X3) DATE SURVEY		
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	· · ·	COMPLETED	
			A. DOILDING	с			
		345373	B. WING		0.	1/17/2014	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
				630 FODALE AVENUE			
OCEAN T	RAIL HEALTHCARE & R			SOUTHPORT, NC 28461			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORF	RECTION	(X5)	
PRÉFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)		COMPLETIO	
F 226	Continued From pag	e 38	F 226				
		went back in the room the	_				
		d and NA #1 used the					
		e resident out of bed. The NA					
		tness inappropriate behavior					
	by NA #1 while she w	was in the room.					
	The Administrator et	stad in an interview an					
		ated in an interview on hat when she was notified of					
		4 it was the end of the shift					
		b go home. The Administrator					
		rning meeting on 1/6/14 with					
	the Director of Nursi	ng and the Social Worker					
		about whether or not NA #1					
		d. The Administrator stated					
		ad a consult note dated					
		nt ' s psychologist that the to him an event with similar					
		Administrator stated that					
		ON brought her the employee					
	-	that Resident #2 alleged the					
	NA had kicked her. T	The Administrator stated that					
		ed around 11:00 on the					
	morning of 1/6/14.						
	Med Aide #2 stated i	n an interview on 1/14/14 at					
		14 she observed Resident #1					
		hair in the hall with no shoes					
		he Med Aide stated Resident					
	-	were jerking her around and					
		d had been kicked and did					
		ed Aide stated that NA #1					
		and asked if she had called					
		abuse and stated she was ess. Med Aide #2 stated she					
	-	Director of Nursing (ADON)					
		to Nurse #1. The Med Aide					
		ke the resident back to her					
	room but the residen	twos upset and did not want					
	100m but the residen	t was upset and did not want					

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	S FOR MEDICARE &					0.0938-03	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COMF	SURVEY	
			A. BUILDING	3			
		345373	B. WING			С	
	ROVIDER OR SUPPLIER	545575		STREET ADDRESS, CITY, STATE, ZIP CO		17/2014	
	ROVIDER OR SUPPLIER				DE		
OCEAN TH	RAIL HEALTHCARE & R	EHAB CENTER		630 FODALE AVENUE SOUTHPORT, NC 28461			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	E APPROPRIATE	COMPLETIO	
F 226	Continued From page	- 39	F 22	26			
	on that day the resident was in the dining room and stated she talked to the lady in the office but						
		not do anything. The Med					
		had heard NA #1 say that as					
		Administrator) was in the					
	building she would ha	-					
		n interview on 1/14/14 at 5:20					
	-	st medication pass she got					
		om and the resident was					
		e Nurse stated the resident a ring in her lip slung her					
		he Nurse stated that NA #1					
		king with a lip ring. The					
		resident had told her she					
		ch so she instructed NA #1 to					
		e resident up and to take NA					
	#2 with her. The Nurs	se stated that NA #1 stated:					
	" I ' II get her up wher	n I ' m good and ready to get					
		lking down the hall. The					
		#2 came out of the room					
		and NA #1 was left in the					
		herself. Nurse #1 stated she					
		ot have to yell at her and NA ust the way I talk to people. "					
		Med Aide #2 told her that the					
		cked her. The Nurse stated					
		ut the kick until bedtime and					
		that NA #1 would not be					
	back in her room. Nu	rse #1 stated that Resident					
		g the right word out but had					
	•	I with her. The Nurse stated					
		ed the wrong word, the					
		hat it was the wrong word.					
		t on 1/11/14, Resident #2					
		mes from a distance and					
	-	s they didn ' t fire her. The me of the incident on 1/5/14,					

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/17/201 FORM APPROVEI OMB NO. 0938-039
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345373	B. WING _		C 01/17/2014
NAME OF P	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZI	P CODE
OCEAN TRAIL HEALTHCARE & REHAB CENTER				630 FODALE AVENUE	
OOLAN				SOUTHPORT, NC 28461	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE
F 226	stated: " (Name of A " Nurse #2 stated in an AM that she got to we and Nurse #1 and Me Resident #2 came ou as soon as the door of and pulling on her an had been going on fo that Resident #1 was resident responded a The Nurse stated the some sense but was place and time. The I would be suspended and go around the far what she did, the Adr because she is her da	e 40 #1 up one day and NA #1 dministrator) will not fire me. h interview on 1/15/14 at 7:15 ork on 1/5/14 at 11:00 PM ed Aide #2 told her that it in tears and told them that closes, NA #1 was tugging d kicked her and that this or a week. The Nurse stated believable and that the uppropriately to questions. resident talked like she had not completely oriented to Nurse stated that NA #1 and then come back to work cility saying that no matter ministrator will not fire her aughter ' s best friend.	F 2		
	Nursing) on 1/5/14. On 1/15/14 at 9:00 A interview that recently her about an incident resident and how ups #6 stated she asked the incident and Nurs	OON (Assistant Director of M, Nurse #6 stated in an y Nurse #5 was talking with between NA #1 and a set she was about it. Nurse Nurse #5 if she had reported se #5 told her that she had se #6 stated that NA #1 had a s a mean spirited girl.			
	interview that she wa 1/5/14. The ADON st	M the ADON stated in an s the nurse on call on ated she received a call on le morning and spoke with			

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		ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 02/17/2014 RM APPROVED IO. 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		345373	B. WING		C 01/17/2014		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C			
00541				630 FODALE AVENUE			
OCEAN II	RAIL HEALTHCARE & R	EHAB CENTER		SOUTHPORT, NC 28461			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 226	church and then wen taking statements. The the abuse policy whice could be reassigned of stated that she texted incident and that the The ADON stated that NA #1 's shift was all NA to transport laund she spoke with Reside told her that her knee wheelchair. The ADOC resident that she wou Administrator in the m facility at approximate stated that NA #1 rep morning. The ADON statements under the because she had to m that NA #1 had been stated when she was she received no orien that her first few days through charts and go The ADON stated that books and rounded w stated that she did go computer course that abuse, work safety, e social worker did the over the abuse policy thought she had to hat involved staff before to investigated.	I stated that she went to t to the facility and started he ADON stated she pulled ch stated that the employee or suspended. The ADON I the Administrator about the NA had been reassigned. It by then it was 2:30 PM and most over and assigned the ry. The ADON stated that lent #2 who was tearful and e was pinched in the N stated she told the add handle it with the norning and she left the ely 3:00 PM. The ADON horted to work the next stated she put the Administrator 's door ound with the physicians. Dund lunchtime she learned suspended. The ADON hired as ADON on 4/15/13 hation. The ADON stated is there she was told to go et familiar with the residents. At she looked through policy with the doctors. The ADON o through the facility included resident rights, etc. The ADON stated the abuse training but did not go of the allegation could be	F 22	26			
		ng (DON) stated in an at 10:34 AM that the ADON		Facility ID: 923382	If continuation sho		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		E CONSTRUCTION	(X3) DATE SURVE COMPLETED C	
		345373	B. WING				0 17/2014
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
OCEAN T	RAIL HEALTHCARE & RI	EHAB CENTER			330 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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 226	did not get a very god stated that she spoke that had to be perform make sure everything basically the ADON ' stated that the ADON computer training pro The Administrator sta 1/17/14 at 10:45 AM to work on the morning to resident care on th suspended at 11:00 A The Administrator sta 1/17/14 at 2:00 PM th policy stated that the reassigned or suspen 3a. The facility ' s abu Neglect Policies and 09/2011 on Page 4 un Persons witnessing a involving a resident m to their department su Administrator. 2. Alleg reported to the Admin Immediately is define but ought not exceed the incident. " Page A Protection read: " 1.1 measures to protect m the investigatory proc facility who have been may be reassigned to suspended from duty	ad orientation. The DON with the ADON about tasks and like Infection Control to a was covered and that was is orientation. The DON did go through the facility 's gram. ted in an interview on that when NA #1 came to of 1/6/14 she was assigned e 600 hall and was M. ted in an interview on that the facility 's abuse accused employee could be ided. se policy titled Abuse and Procedures last revised on inder Reporting read: "1. in accident or incident sust report such information upervisor and/or the facility gations of abuse shall be istrator immediately. d as " as soon as possible, 24 hours after discovery of 4 of the policy under This facility shall initiate esidents from harm during tess. 3. Employees of the in accused of resident abuse o nonresident care duties or for up to ten working days investigation have been	F	226			

Facility ID: 923382

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 02/17/2014 RM APPROVED IO. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345373	B. WING		0	C 1/17/2014	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CC			
OCEAN T	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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 226	Resident #1 was adm and had diagnoses th Obstructive Pulmona Disease, Congestive Dementia. The Care Area Assess Status and Communi revealed that the resi- oriented due to progr CAA revealed that the but confused to time verbalize needs and vascular dementia. T resident was resistive cursing at staff. The Quarterly Minimu Assessment dated 11 resident had short an problems and was set The MDS revealed th dependent on staff fo The MDS revealed th behaviors during the The Care Plan dated that the resident was kicking and cursing. A to check the resident needs and address to anxiety or resistive be needed. The Director of Nursi interview on 1/14/14 a report that NA #1 to hoped he fell out of th	hitted to the facility on 5/1/13 hat included COPD (Chronic ry Disease), Coronary Artery Heart Failure and Advanced assment (CAA) for Cognitive cation dated 5/13/13 dent was unable to be essive cognitive decline. The e resident was alert to self and place and unable to concerns secondary to he CAA revealed that the e to care, hitting, kicking and um Data Set (MDS) 1/1/13 revealed that the	F 22	6			

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/17/2014 FORM APPROVED OMB NO. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345373	B. WING _		C 01/17/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE
	OCEAN TRAIL HEALTHCARE & REHAB CENTER			630 FODALE AVENUE	
UCEAN T		ERAD CENTER		SOUTHPORT, NC 28461	
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE COMPLETION O THE APPROPRIATE DATE
F 226	when this occurred. T called the family of Re that this occurred. Th interview with the resi did not witness the im- further because she of The DON stated that in the summer of 201 September. The DON training on abuse by f if she received an alle supposed to fill out a the resident and the s have the staff write a incident. The DON stati information to the Adr discussed the findings Administrator did sep employees and the so resident about the ind she then would get to Administrator and cor determine what actual stated if there was a d employee was suspen investigation. The DON document the allegati The DON stated she to the Administrator. The was DON and do was busy. The Administrator sta 1/14/14 at 3:45 PM th allegation that NA #1	ng room with the resident The DON stated that she esident #1 and they denied e DON stated that her ident 's family revealed they cident so she did not go any did not think it happened. the incident occurred back 3, maybe August or N stated she had received the facility. The DON stated egation of abuse she was concern form and interview staff members involved and statement regarding the ated she then turned in this ministrator and they s. The DON stated the arate interviews with the ocial worker talked with the cident. The DON stated that ogether with the mpare interviews and try to ally happened. The DON concern about abuse the nded pending results of the DN stated she did not ion or the family interview. failed to report the incident The DON stated at the time sing MDS assessments and	F 2		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				RINTED: 02/17/2014 FORM APPROVED MB NO. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE SURVEY COMPLETED	
		345373	B. WING		_	C 01/17/2014	
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				630 FODALE AVENUE			
OCEAN TRAIL HEALTHCARE & REHAB CENTER				SOUTHPORT, NC 2846	1		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 226	incident was being inv Nurse #2 stated in an AM that she heard that she hoped he fell out	vestigated. interview on 1/15/14 at 7:15 at NA #1 told Resident #1 of the wheelchair so he had	F 22	6			
	to go to the hospital and would not have to take care of him. The Nurse stated that she did not witness the incident. The Nurse stated that NA #1 would be suspended and then come back to work and go around the facility saying that no matter what she does, the Administrator will not fire her because she is her daughter 's best friend.						
	NA (nursing assistant) #3 stated in an interview on 1/16/14 at 10:50 AM that she observed NA #1 push Resident #1 to the dining room in his geri-chair. The NA stated that the resident was trying to scoot out of the chair like he always did. The NA stated she heard NA #1 say to the resident: " I hope you fall out of the chair so they can send you to the hospital. " The NA stated that this happened in August or September of 2013. The NA stated that another resident and his spouse were sitting at the next table and the NA made the statement loud enough for them to hear but did not know if they actually heard the statement made by NA #1. NA #3 stated that she reported the incident to the weekend supervisor on duty that day and the supervisor had her write a statement about the incident. The NA stated that the weekend supervisor no longer worked at the facility. NA #3 stated that NA #1 talked very nasty to the residents and she had told the NA that this was not the kind of work for her. NA #3 stated that NA #1 gets written up and suspended with pay and she comes right back to work and nothing happens. NA #3 stated that NA #1 gets suspended and comes back and brags that they						

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 02/17/2014 MAPPROVED 0. 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345373	B. WING			C 01/17/2014		
NAME OF PF	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
00541				63	0 FODALE AVENUE			
OCEAN II	OCEAN TRAIL HEALTHCARE & REHAB CENTER			so	OUTHPORT, NC 28461			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 226	Continued From page	e 46	F	226				
	Nurse #5 stated in an PM that she had report and was told to write The Nurse stated she because she knew no Nurse stated a NA wa incident where a resid NA was terminated. The brags that she is the la administrator 's daug will not do anything to 3b. The facility 's abu Neglect Policies and 09/2011 on Page 4 un Persons witnessing a involving a resident m to their department su Administrator. 2. Alleg reported to the Admin Immediately is define but ought not exceed the incident. " The fa Abuse and Neglect P revised on 09/2011 of read: " 1. Persons wi incident involving a re- information to their de- the facility Administrator shall be reported to the immediately. Immedia as possible, but ough discovery of the incid under Protection read	a interview of 1/16/15 at 3:00 orted NA #1 multiple times a letter to the Administrator. a did not write the letter othing would happen. The as hired and there was an dent 's arm was hurt and the 'he Nurse stated NA #1 best friend of the ghter and the Administrator o her. se policy titled Abuse and Procedures last revised on nder Reporting read: "1. n accident or incident nust report such information apervisor and/or the facility gations of abuse shall be itstrator immediately. d as " as soon as possible, 24 hours after discovery of cility 's abuse policy titled olicies and Procedures last n Page 4 under Reporting thessing an accident or esident must report such epartment supervisor and/or tor. 2. Allegations of abuse						
	the facility who have	ry process. 3. Employees of been accused of resident gned to nonresident care						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345373	B. WING			C 01/17/2014	
NAME OF P	ROVIDER OR SUPPLIER		ł	s	STREET ADDRESS, CITY, STATE, ZIP CODE		
OCEAN T	RAIL HEALTHCARE & RI	EHAB 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 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 226	duties or suspended f working days until the have been reviewed f Resident #1 was adm and had diagnoses th Obstructive Pulmonan Disease, Congestive Dementia. The Care Area Asses Status and Communi- revealed that the resid- oriented due to progre CAA revealed that the but confused to time a verbalize needs and o vascular dementia. Th resident was resistive cursing at staff. The Quarterly Minimu Assessment dated 11 resident had short an problems and was se The MDS revealed th dependent on staff fo The MDS revealed th behaviors during the The Care Plan dated that the resident was kicking and cursing. A to check the resident needs and address to anxiety or resistive be needed.	from duty for up to ten e results of the investigation by the Administrator. " hitted to the facility on 5/1/13 hat included COPD (Chronic ry Disease), Coronary Artery Heart Failure and Advanced sment (CAA) for Cognitive cation dated 5/13/13 dent was unable to be essive cognitive decline. The e resident was alert to self and place and unable to concerns secondary to he CAA revealed that the e to care, hitting, kicking and im Data Set (MDS) /1/13 revealed that the	F	226			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	2: 02/17/2014 APPROVED 0: 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345373	B. WING		_	(01/	C 17/2014
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE	-	
OCEAN T	RAIL HEALTHCARE & RI	EHAB CENTER		630 FODALE AVENUE SOUTHPORT, NC 2846	:1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 226	that this happened aw specific about a date. happened around the to tell the resident that the wheelchair and ha (August/September 2 she reported the incid questioned about the Nurse #3 stated in an PM that NA #2 came she should do if she s thumped on the head did not say who the re thumping a resident of stated she told the N/ nurse. NA #2 was ask stated that she though to Nurse #3. Nurse #3 NA #2 wanted information out. Nurse #3 stated s NA told her to anyone NA #1 was suspender reported the incident of The Administrator sta 1/14/14 at 3:45 PM the allegation that NA #1 head. The Administra considered thumping be abusive and Nurse	A that she walked in and observed NA #1 c on the head. The NA stated while back but could not be The NA stated that this time that NA #1 was heard t she hoped he fell out of ad to go to the hospital 013). The NA stated that ent Nurse #3 but was never incident. interview on 1/14/14 at 2:55 to her and asked her what saw someone being . The Nurse stated the NA esident was or who was in the head. The Nurse A she should report it to her sed to join the interview and ht she reported the incident 8 stated that she took it that ation. NA #2 stated she did t to anyone else but it got she did not report what the e else but shortly afterwards, d so she thought the NA had to her nurse. ted in an interview on at she was not aware of the thumped Resident #1 on the tor stated that she the resident on the head to e #3 should have attempted to	F 22	26			

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	-	ND HUMAN SERVICES MEDICAID SERVICES				F	ITED: 02/17/2014 ORM APPROVED NO. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PRO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OATE SURVEY OMPLETED	
		345373	B. WING			C 01/17/2014		
NAME OF PROVIDER OR SUPPLIER OCEAN TRAIL HEALTHCARE & REHAB CENTER				630	EET ADDRESS, CITY, STATE, ZIP COD FODALE AVENUE UTHPORT, NC 28461	E		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			x	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 226	Jeopardy on 1/16/14 provided a credible a 1/17/14 at 1:55 PM. T indicated: For Resident #1, the unaware of allegation Resident #1. The DO report the allegation function undetermined when t place. The resident is 24-hour report has be 5-day will be complet NA #1 was terminate • The DON has re- the administrator and consultant for failing fabuse to the administrator and consultant for failing fabuse to the administrator or all allegations. For the second alleganotified on 1/16/14 by Resident #1. The C.N clearly report to the m the employee respon It is undetermined wh place. The resident is A 24-hour report has 5-day will be complet The accused NA #1 w	Is notified of the Immediate at 10:00 AM. The facility llegation of compliance on The allegation of compliance facility Administrator was a #1 against NA #1 to N was aware and failed to to the administrator. It is the alleged incident took a deceased (11/4/13). A een completed 1/17/14. A ted by 1/21/14. The accused d 1/16/14. ceived disciplinary action by the corporate nurse to report an allegation of trator. The DON was etor of operations and the sultant on the abuse policy in requirements for reporting A.A. was aware and failed to nurse the alleged abuse and sible. then the alleged incident took a deceased (11/4/13). been completed 1/17/14. A	F	226				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				LE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED C 01/17/2014					
345373			B. WING							
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE						
OCEAN T	RAIL HEALTHCARE & RI	EHAB 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 TAGPROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				BE	(X5) COMPLETION DATE				
F 226	the DON and an inser with concentration on all allegations. For Resident #2, rem NA #1 was suspende investigation. An inve was completed 1/9/14 work 1/10/14 after col but not to the care an NA #1 was suspende subsequently termina A 24-hour and 5-day 1 1/15/14. • The Administrato action from the direct initiate and complete reports on allegations retrained by the direct corporate nurse cons with concentration on all allegations. • The DON has react the administrator and consultant for failing t abuse to the administ retrained by the direct corporate nurse cons with concentration on all allegations. For Resident #8, an in 1/9/14. NA #1 was su	eceived disciplinary action by rvice on the abuse policy requirements for reporting ains in the facility. d 1/6/14 pending stigation of the allegation 4. NA #1 was returned to mpletion of the investigation d service of Resident #2. d again 1/13/14 and ted 1/16/14. report was completed or has received disciplinary or of operations for failing to the 24-hour and 5-day s. The Administrator was tor of operations and the ultant on the abuse policy requirements for reporting ceived disciplinary action by the corporate nurse to report an allegation of	F	220	6					

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 02/17/201 MAPPROVE D. 0938-039
		CIES (X1) PROVIDER/SUPPLIER/CLIA (.		TIPLE NG	(X3) DATE SURVEY COMPLETED		
		345373	B. WING				C / 17/2014
NAME OF PI	ROVIDER OR SUPPLIER			S	IREET ADDRESS, CITY, STATE, ZIP CODE		-
	RAIL HEALTHCARE & R			63	30 FODALE AVENUE		
OCEAN II				S	OUTHPORT, NC 28461		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	Continued From page	e 51	F.	226			
1 220	10	4 pending investigation. NA		220			
		ork 1/10/14 after completion					
		ut not to the care and service					
	of #2.						
	Resident #3 was disc	charged 1/7/14.					
		ent deceased in the hospital.					
	NA #1 was suspende	•					
	subsequently termina						
	1/15/14.	report was completed on					
	• The Administrate	or has received disciplinary					
	action from the direct	tor of operations for failing to					
		the 24-hour and 5-day					
		s. The administrator was					
		ctor of operations and the sultant on the abuse policy					
	-	requirements for reporting					
	all allegations.						
	For those residents h	naving the potential to be					
	affected by the same	alleged deficient practice:					
	• The Social Work	ker asked all residents					
		rviewed if they had ever felt					
	-	member of the facility. All					
		d denied feeling mistreated					
	by any member of the	e staff. ⁻ the facility had a Resident					
		The facility had a Resident Thursday, January 16, 2014.					
		eminded of their right to be					
		erent types of abuse and how					
	and who to report it t						
		ve staff have been					
		acility 's Abuse Policy and					
	-	rporate Nurse Consultant.					
		yees will be re-educated on					
		Policy and Procedure by the rector of Nursing and will be					

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	-	ND HUMAN SERVICES MEDICAID SERVICES					FORM): 02/17/20 ² 1 APPROVE). 0938-039		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		345373	B. WING			C 01/17/2014				
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CO	DE				
OCEAN TRAIL HEALTHCARE & REHAB CENTER					FODALE AVENUE UTHPORT, NC 28461					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIA		(X5) COMPLETIO DATE		
F 226	mandated to attend to Procedure inservice of 11:30 AM, 90% of all inserviced on the abu- not be allowed to work inserviced. • The Social Work parties of residents up themselves to inquire in resident behavior to abuse. • The nursing staff for injuries of unknow to speak for themselve • Employees who abuse and failed to re- disciplinary action. • The Administrator action from the Direct to initiate and comple- reports on allegations retrained by the Direct Corporate Nurse Cor- with concentration or all allegations. • The DON has re- the administrator and Consultant for failing abuse to the adminis- retrained by the Direct Corporate Nurse Cor- with concentration or all allegations. • The DON has re- the administrator and Consultant for failing abuse to the adminis- retrained by the Direct Corporate Nurse Cor- with concentration or all allegations. On 1/17/14 at 3:00 P validated by random	he Abuse Policy and quarterly. On 1/17/14 at employees had been use policy. Employees will rk until they have been er contacted all responsible nable to speak for e of any concerns or changes hat could indicate possible f has completed a skin check whorigin of residents unable ves. reportedly knew of resident eport have received or has received disciplinary tor of Operations for failing ete the 24-hour and 5-day s. The Administrator was chor of Operations and the neulirements for reporting ceived disciplinary action by I the Corporate Nurse to report an allegation of trator. The DON was chor of Operations and the neulirements for reporting M the credible allegation was interviews with staff showing eived inservices on the cises and procedures.	F	226						

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CENTERS FOR MEDICARE & MEDICARD SERVICES OMB NO. 0938-0391 AND PLAN OF CORRECTION (XI) PROVIDER ORUPULER (X) MUTTIPLE CONSTRUCTION (X) DATE UNCY' AND PLAN OF CORRECTION (X) MUTTIPLE CONSTRUCTION (X) DATE UNCY' (X) MUTTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X) MUTTIPLE CONSTRUCTION (X) MUTTIPLE CONSTRUCTION (X) COMPLETED A BUILDING (X) MUTTIPLE CONSTRUCTION (X) MUTTIPLE CONSTRUCTION (X) COMPLETED OCEAN TRAIL HEALTHCARE & REHAB CENTER STREET ADDRESS, CITY, STATE, ZIP CODE (X) MUTTIPLE CONSTRUCTION (X) MUTTIPLE CONSTRUCTION (X) PROVIDER OR SUMPLIER (X) MARY STATEMENT OF DEFICIENCIES (X) MUTTIPLE CONSTRUCTION (X) MUTI			ID HUMAN SERVICES				FORM	APPROVED
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED A. BUILDING				(X2) MUL	TIPI F			
Image: Street Address, citry, state, zip code NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE OCEAN TRAIL HEALTHCARE & REHAB CENTER STREET ADDRESS, CITY, STATE, ZIP CODE OCEAN TRAIL HEALTHCARE & REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (x5) OMPLETION ID PROVIDER'S PLAN OF CORRECTION SHOULD BE (x5) PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX CONSS-REFERENCED TO THE APPROPRIATE OMPLETION F 226 Continued From page 53 F 226 F 226 F 226 F 226							COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE OCEAN TRAIL HEALTHCARE & REHAB CENTER 630 FODALE AVENUE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION) ID PREFIX F 226 Continued From page 53 F 226 F 226 Knowledgeable about the definition of abuse and the different kinds of abuse. The staff voiced understanding they were to report instances of F 226								
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 226 Continued From page 53 knowledgeable about the definition of abuse and the different kinds of abuse. The staff voiced understanding they were to report instances of F 226			345373	B. WING	_		01/	17/2014
OCEAN TRAIL HEALTHCARE & REHAB CENTER 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 226 Continued From page 53 knowledgeable about the definition of abuse and the different kinds of abuse. The staff voiced understanding they were to report instances of F 226	NAME OF PF	ROVIDER OR SUPPLIER						
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE F 226 Continued From page 53 knowledgeable about the definition of abuse and the different kinds of abuse. The staff voiced understanding they were to report instances of F 226 F 226 Continued From page 53 F 226	OCEAN TR	RAIL HEALTHCARE & RI	EHAB CENTER					
F 226 Continued From page 53 F 226 knowledgeable about the definition of abuse and the different kinds of abuse. The staff voiced understanding they were to report instances of F 226	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL				(EACH CORRECTIVE ACTION SHOULD B		COMPLETION
knowledgeable about the definition of abuse and the different kinds of abuse. The staff voiced understanding they were to report instances of	TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	i		AIE	DAIL
knowledgeable about the definition of abuse and the different kinds of abuse. The staff voiced understanding they were to report instances of	F 226	Continued From page	e 53	F	226			
understanding they were to report instances of		knowledgeable about	the definition of abuse and					
		-						

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