**NAME OF PROVIDER OR SUPPLIER**

OCEAN TRAIL HEALTHCARE & REHAB CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**

630 FODALE AVENUE
SOUTHPORT, NC 28461

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### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

**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*

**COMPLETION DATE**

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**F 000 INITIAL COMMENTS**

There were no deficiencies cited as a result of this complaint investigation survey of 11/13/14. Event ID# HG4811. Intakes NC00101830, NC00100370, NCNC00100418.

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**LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE**

**TITLE**

**DATE**

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**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.