	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		E SURVEY
	CONNECTION	IDENTIFICATION NOMBER.	A. BUILDII	NG			C
		345373	B. WING _			11	U/19/2015
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 1	1/13/2013
				63	0 FODALE AVENUE		
OCEAN T	RAIL HEALTHCARE & R	EHAB CENTER		sc	OUTHPORT, 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	x	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 000	INITIAL COMMENTS	3	F	000			
		as a result of complaint					
F 004	-	QLU11 on 11/19/2015.					10/0/45
F 221 SS=D	483.13(a) RIGHT TO PHYSICAL RESTRA			221			12/9/15
	physical restraints im	right to be free from any posed for purposes of					
	discipline or convenie treat the resident's m	ence, and not required to edical symptoms.					
	This REQUIREMENT	⊺ is not met as evidenced					
	-	ns, staff interviews, and			This plan of correction is provided as a	a	
		ility failed to have a medical			necessary requirement of continued		
	•	belt restraint for 1 of 1			participation in the Medicare and Medic		
		nt reviewed for restraints.			Programs and does not, in any manner		
	Findings included: Record review indica	ted resident #29 was			constitute an admission to the validity of the alleged deficient practice.	זנ	
		y on 11/29/12. The resident '			the dileged denoicht produce.		
		es included Cerebral Palsy,			For the resident found to have been		
	Intellect Disability, Ep	pilepsy, Anxiety and			affected by the alleged deficient practic	æ,	
	Scoliosis.				resident #29, the residents need for		
		prehensive assessment cated resident required total			assistive devices was reassessed by the Rehab staff. As a result of this	ne	
		sing, eating, toilet use and			assessment, the seatbelt was removed	ł.	
	personal hygiene. As	sessment revealed resident nd others, had slurred or			Completion Date: 12/03/2015		
	mumbled words, had	no problem with short term			For those residents having the potentia		
		nory problem recalling long			be affected by the same alleged deficie		
	•	ity to recall included location mes and faces and that she			practice, the DON has completed an au of all residents to determine whether ar		
		nome. Resident noted to			residents were found with an assistive	''y	
	have severe cognitive				device that could be considered a		
	assessment indicated	d resident had behavioral			restraint.		
		ered with her care and her			Completion Date: 12/03/2015		
	participation in activit	ies and social interactions.					

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.

12/09/2015

	-	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/14/201 FORM APPROVEI OMB NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345373	B. WING		C 11/19/2015
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE	
OCEAN T	RAIL HEALTHCARE & R	EHAB CENTER		330 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 OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 221	restraints in or out of The resident 's recor- evaluation and no do was found in the med Resident #29 observa On 11/16/2015 at 3:0 observed in specialty station with an abdom canvas type material her midsection with 3 each side of the devia in the back of the chair resident was observe crying out at intervals observed talking with past the nurse 's stat On 11/16/2015 at 5:1 in specialty chair at s buckled in back of ch attempting to move fr in specialty chair duri On 11/17/2015 at 103 observed in specialty the device buckled in noted attempting to m specialty chair during On 11/18/2015 at 5:0 in specialty chair at s buckled in back of ch attempting to move fr during each observat In an interview with th Nursing on 11/18/2017 resident had the seat She reported the sea from intentionally thru chair. She stated the	ded as having no physical bed. d was reviewed. No restraint cumentation of the seat belt dical records. ations: 0 PM, resident was of chair beside Unit 1 nurse 's ninal device made from thick 12 inches in width around 6 inch straps attached to ce, the straps were secured air with a buckle. The ed moving all extremities and 6. Several staff members resident as they walked tion. 5 PM resident was observed ame location with the device air. Resident was noted rom side to side and wiggling ng observation. 30 AM resident was of chair at same location with back of chair. Resident was nove from side to side in observation. 5 PM resident was observed ame location with the device air. Resident was noted rom side to side in specialty ion. Assistant Director of 15 at 4:30 PM, she stated belt in her chair at all times. tbelt prevented the resident usting herself out of the	F 221	To ensure that the alleged deficien practice does not recur, all nurses cna's will be in-serviced on restrair and proper assessment of devices could be considered a restraint. Additionally, nurses will be in-servi updating care plans when a restrai place or has been removed. Restr use will be discussed with the Rehabilitation and clinical team at weekly PAR (Patients at Risk) mee Completion Date: 12/09/2015 In order to monitor our performance to ensure the solutions are sustain resident identified going forward, we discussed at the weekly PAR meet the interdisciplinary team in order to identify the least restrictive devices ensure the appropriate documenta completed. We will integrate this p correction into our ongoing Quality Assurance program. The DON will review/audit our compliance weekl four weeks, then monthly for three months. Completion Date: 12/09/2015 and ongoing.	and th use that ced on int is in raint the eting. e and ed, any <i>v</i> ill be ting with to s and to tion is lan of I y for

If continuation sheet Page 2 of 11

	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED
		345373	B. WING		C 11/19/2015
NAME OF P	ROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP CO	DE
OCEAN T	RAIL HEALTHCARE & R	EHAB CENTER		FODALE AVENUE JTHPORT, 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 COMPLETION TE APPROPRIATE DATE
F 221 F 272 SS=D	was unable to remove In an interview with D 11/18/2015 at 4:50 Pl leaned to the side an the chair. She reporte of purposeful and inter- chair, and at times at of the chair. She stat from falling out of the the device was discu- therapist several more was not a restraint. He facility to use the lease indicated and for it to assessed. 483.20(b)(1) COMPE ASSESSMENTS The facility must cond a comprehensive, act reproducible assesses functional capacity. A facility must make a assessment of a resident resident assessment by the State. The ass least the following: Identification and der Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior p Psychosocial well-be	ed. She indicated resident e the device. Prirector of Nursing on M, she indicated the resident d the belt supported her in ed the resident was capable entional movements in the tempted to push herself out ted the device prevented her chair. She also indicated ssed with the occupational of the ago and was informed it der expectation was for the st restrictive device when be properly evaluated and EEHENSIVE duct initially and periodically curate, standardized nent of each resident's a comprehensive dent's needs, using the instrument (RAI) specified sessment must include at nographic information;	F 221		 12/9/15

Facility ID: 923382

If continuation sheet Page 3 of 11

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/14/2015 FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345373	B. WING		11/19/2015
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 PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 272	the additional assess areas triggered by the Data Set (MDS); and	nd health conditions; I status; nd procedures; mmary information regarding ment performed on the care e completion of the Minimum	F 272		
	by: Based on record rev interviews, the facility resident reviewed wit (resident #29) Findings included: Record review indica admitted to the facility s cumulative diagnos Intellect Disability, Ep Scoliosis. The most r assessment dated 1// required total depend toilet use and person revealed resident wa had slurred or mumb with short term memor recalling long past. H	y on 11/29/12. The resident ' es include Cerebral Palsy,		This plan of correction is provide necessary requirement of contini- participation in the Medicare and programs, and does not, in any r constitute an admission to the va- the alleged deficient practice. For the resident found to have be affected by the alleged deficient a comprehensive assessment was completed on 12/03/2015. As a this assessment, an order was re by the Attending Physician and th seatbelt was removed. Completion Date: 12/03/2015 For those residents having the p be affected by the same alleged	ued Medicaid manner, alidity of een practice, as result of eceived he

Facility ID: 923382

If continuation sheet Page 4 of 11

						r –	O. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` '		CONSTRUCTION		E SURVEY IPLETED
			A. BUILDING	G			С
		345373	B. WING				U/19/2015
	ROVIDER OR SUPPLIER	040010			REET ADDRESS, CITY, STATE, ZIP CODE	11	/19/2015
	CONDER OR SOLT EIER				0 FODALE AVENUE		
OCEAN TR	RAIL HEALTHCARE & R	EHAB CENTER			DUTHPORT, NC 28461		
				30	•		
(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 APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
F 272	Continued From page	9 4	F 27	72			
		sided in a nursing home.			practice, the MDS nurse has audited		
		o have severe cognitive			100% of residents assessments, to		
	impairment. The asse	U			determine that any restraints or assistiv	/e	
	resident had behavior	ral symptoms that interfered			devices have been properly assessed.		
		participation in activities			Completion Date: 12/03/2015		
	and social interaction						
		ssessment dated 1/21/2015			To assure that the alleged deficient		
	subsequent quarterly	t did not have any restraints,			practice does not recur, the following measures have been put into place; All		
		5 indicated the resident did			nurses and cna's have been in-service		
		ts. The most recent quarterly			on restraint use, assessment of device		
	assessment dated 9/3				that could be considered a restraint, an		
	resident did not have	any restraints.			the appropriate assessments of these		
	On 11/16/2015 at 3:0	0 PM, the resident was			devices while in place and reassessme	ents	
		chair beside Unit 1 nurse ' s			when removed. Restraint assessments		
		ninal device made from thick			will be reviewed with the interdisciplina	ry	
		12 inches in width around			team at the weekly PAR meetings.		
		inch straps attached to ce, the straps were secured			Completion Date: 12/09/2015		
		ir with a buckle. Resident			In order to monitor our performance an	Ч	
		to move from side to side			to make sure that the solutions are	ŭ	
		nities during observation.			sustained, any resident identified going	1	
		5 PM resident was observed			forward will be discussed and the week	kly	
	in specialty chair besi	ide Unit 1 nurse 's station			PAR meeting with the interdisciplinary		
	with the device aroun				team in order to identify the least		
		back of chair. Resident was			restrictive devices and to ensure the		
		nove from side to side and			appropriate documentation is complete		
	moving all extremities On 11/17/2015 at 103				We will integrate this plan of correction into our on-going Quality Assurance		
		chair beside Unit 1 nurse ' s			program. The DON will review/audit or	ır	
		e around her midsection and			compliance weekly for four weeks then		
		back of chair. Resident was			monthly for three months.		
	noted attempting to m	nove from side to side and			Completion Date: 12/09/2015		
	moving all extremities	-					
		5 PM resident was observed					
		ide Unit 1 nurse 's station					
	with the device aroun						
	tastened/buckled in b	ack of the chair. Resident					

Facility ID: 923382

If continuation sheet Page 5 of 11

		ND HUMAN SERVICES MEDICAID SERVICES			FORM	D: 12/14/201 // APPROVE). 0938-039
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345373	B. WING			C 19/2015
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI		
				630 FODALE AVENUE		
OCEAN TH	RAIL HEALTHCARE & R	EHAB CENTER		SOUTHPORT, NC 28461		
(X4) ID	SUMMARY ST	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 A CROSS-REFERENCED TO DEFICIE	O THE APPROPRIATE	COMPLETION DATE
F 272	Continued From page	e 5	F 27	72		
		nities during observation.				
	In an interview with th	5				
	11/18/2015 at 3:36 P					
		sments and recorded the				
	information in the ME	S system. She stated she				
		elt was not coded as a				
		recall the device being				
		dent 's care plan meeting at				
	-	e seatbelt was there to				
		from falling from the chair, would thrust herself out of				
		ed the seatbelt had always				
		's chair, and the resident				
		to remove the device.				
	In an interview with th	ne Assistant Director of				
	Nursing on 11/18/207	15 at 4:30 PM, she stated the				
		esident ' s chair at all times.				
		tbelt prevented the resident				
		usting herself out of the				
		resident purposefully				
	desired to return to b	of the chair, especially if she				
	resident was unable					
		ne Director of Nursing on				
		M, she indicated the resident				
		nd the belt supported her in				
	the chair. She reported	ed the resident was capable				
		entional movements in the				
		tempted to push herself out				
		ted the device prevented the				
		out of the chair. The DON				
		n was the facility would have tive device when indicated				
		rly evaluated and assessed.				
F 279	483.20(d), 483.20(k)	-	F 27	79		12/9/15
SS=D	COMPREHENSIVE (
	A facility must use the	e results of the assessment				
RM CMS-256	7(02-99) Previous Versions Ob	solete Event ID: TQL		Facility ID: 923382	If continuation she	

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 12/14/2015 MAPPROVED O. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY IPLETED
		345373	B. WING		11	C / /19/2015
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP 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 OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 279	to develop, review and comprehensive plan of The facility must develop plan for each residen objectives and timetal medical, nursing, and needs that are identif assessment. The care plan must d to be furnished to attachighest practicable pl psychosocial well-bei §483.25; and any ser be required under §4 due to the resident's	Id revise the resident's of care. elop a comprehensive care t that includes measurable bles to meet a resident's d mental and psychosocial ied in the comprehensive escribe the services that are ain or maintain the resident's	F 27	9		
	by: Based on observation interviews, the facility comprehensive care reviewed with a restration Findings included: Record review indica admitted to the facility s cumulative diagnoss Disability, Epilepsy, A The annual Minimum 1/21/2015 did not coor The MDS indicated the dependent on staff for	plan for 1 of 1 resident aint (Resident # 29). ted Resident #29 was y on 11/29/12. The resident ' es included Intellect		This plan of correction is provid necessary requirement of conti participation in the Medicare ar Program and does not, in any r constitute an admission to the the alleged deficient practice. For the resident found to have affected by the alleged deficien resident #29, an assessment w performed by the Rehabilitation department, and due to her cur of disability, it was determined belt was not warranted for the p support. A physicians order wa and the belt was removed on 1	nued nd Medicaid nanner, validity of been t practice, as rent level that the purpose of as obtained	

Facility ID: 923382

If continuation sheet Page 7 of 11

TATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DAT	10. 0938-039 FE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	NG _		CON	MPLETED
		345373	B. WING			1	C 1/19/2015
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 1	1/15/2015
					30 FODALE AVENUE		
OCEAN TI	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 279	Continued From page	o 7		279			
1 215				219	Completion Date: 12/02/2015		
		e to understand others, had vords, had no problem with			Completion Date: 12/03/2015		
		ut had long term memory			For those residents having the poten	tial to	
		29 noted to have severe			be affected by the same alleged defi		
	- ·	. The assessment indicated			practice, 100% of residents care plar		
		avioral symptoms that			have been audited by the DON. The		
		re and her participation in			plan for each resident has been mod		
		nteractions. The Care Area ated 1/21/2015 regarding			as appropriate for any device that is, could be considered a restraint.	or	
	falls indicated to proc				Completion Date: 12/03/2015		
		led the resident 's Care Plan					
		ded the resident was at risk			To assure that the alleged deficient		
	for falls due to history	of thrusting herself out of			practice does not recur, the following	l	
		aches for this problem			measures have been put into place.		
	-	heel chair with anti-thrust			nurses and cna's have been in-servio		
		seat belt. A revision to the			on restraint use, assessment of device	ces	
	-	/15 indicated the high back nion and the seat belt were			that could be considered a restraint, comprehensive care plans, and the		
		re plan dated 10/15/2015			appropriate assessment of these dev	vices	
		y chair, and the seatbelt was			while in place and when discontinued		
	not addressed.	,,			changes required in the Care plan, w	-	
	An observation of the	e resident on 11/16/2015 at			reviewed by the Interdisciplinary tear		
	3:00 PM revealed the	e resident in a specialty chair			the weekly PAR (Patients At Risk)		
		s station with an abdominal			meetings.		
		ck canvas type material 12			Completion Date: 12/09/2015		
		nd her midsection with 3 inch ich side of the device, the			In order to monitor our porformance	and	
		in the back of the chair with			In order to monitor our performance to make sure that these solutions are		
		nt moved all extremities and			sustained, any resident identified goi		
		om side to side and was			forward will be discussed at the weel	•	
	unable to.				PAR meeting with the interdisciplinar	y	
		e resident on 11/16/2015 at			team in order to identify any changes		
		e resident in a specialty chair			care plans and to ensure the approp		
		tion with the device buckled			documentation is completed. We will		
		air. The resident moved all			integrate this plan of correction into c		
	side and was unable	npted to move from side to			on-going Quality Assurance program The DON will review/audit our compl		
		/17/2015 at 10:30 AM			weekly for four weeks and then mon		
		in a specialty chair at Unit 1			for three months.	,	

Facility ID: 923382

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/14/2015 MAPPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345373	B. WING _				C 19/2015
NAME OF P	ROVIDER OR SUPPLIER			ST	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 PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	nurse 's station with back of the chair. The extremities and attern side and was unable An observation on 11 revealed the resident nurse 's station with back of the chair. The extremities and attern side and was unable In an interview with th nurse on 11/18/2015 she was responsible revisions. She review dated 7/15/2015 for r nurse stated the seat been discontinued an mistake that I didn 't . The MDS nurse into plan for the resident 't the device being disc plan meeting at any t reported the seatbelt falling from the chair, thrust herself out of th seatbelt had always the chair, and the resider remove the device. In an interview with th Nursing (ADON) on 1 ADON stated the resident at chair, especially if sho The ADON also report to remove the device	the device buckled in the e resident moved all opted to move from side to to. /17/2015 at 505 PM in a specialty chair at Unit 1 the device buckled in the e resident moved all opted to move from side to to. ne Minimum Data Set (MDS) at 3:36 PM, she indicated for the care plans and red the Care Plan revision esident #29. The MDS belt for the chair had not ad further stated " it was my put it back on the care plan " dicated there was no care s seat belt and did not recall ussed in the resident ' s care ime. The MDS nurse also prevented the resident from because the resident from because the resident would ne chair. She indicated the been on the resident ' s at had never been able to ne Assistant Director of 1/18/2015 at 4:30 PM, the ident had the seatbelt in the imes. She reported the e resident from intentionally of the chair. The ADON tempted to get out of the e desired to return to bed. rted the resident was unable	F2	279	Completion Date: 12/09/2015		

Facility ID: 923382

If continuation sheet Page 9 of 11

STATEMENT OF DEPICIENCES INDEX.NO PLAN OF CORRECTION (XI) PROVIDER OF UNDERSON (XII) PROVIDER OF UNDERSON (XIII) PROVIDER OF UNDERSON (XIII) PROVIDER OF UNDERSON (XIII) PROVIDER OF UNDERSON (XIIII) PROVIDER OF UNDERSON (XIIIIII) PROVIDER OF UNDERSON (XIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII		-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	ED: 12/14/2015 MAPPROVED O. 0938-0391
11/19/2015 NMME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE CECAN TRAIL HEALTHCARE & REHAB CENTER SUMMARY STATEMENT OF DEPORPORE Visition Recoll FORCINCY WUSTER PROCEDED BY FULL. DEPORPTION PRETIX Continued From Provide Response Continue Provide Response Continue Provide Response Continue Response				. ,		· · /	IPLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STREET, PC CODE OCEAN TRAIL HEALTHCARE & REHAB CENTER SOUTHORT, NC 24841 (PA) ID PREEIX TAG ISLIMMARY STREEMENT OF DEFICIENCIES (PADI DEFICIENCY MOST OF PRECEDD BY FULL REGULATORY OR LSC DENTITYING INFORMATION) ID PREVIX PREVIX TAG PROVIDER'S PLAN OF CORRECTION (PADI DEFICIENCY) PROVIDER'S PLAN OF CORRECTION (PADI DEFICIENCY) OVER (PADI DEFICIENCY) F 279 Continued From page 9 11/18/2015 at 4:50 PM, she indicated the resident leaned to the side, and the belt supported her rin the chair. She spotted the resident was capable of intentional movements in the chair, and at times attempted to push hersef of up to the spectation was the facility would have used the least restrictive device prevented the resident device to be care planned. F 354 F 334 483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, SS=F F 354 Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse to serve as the director of nursing on a full time basis. This plan of correction is provided as a necessary reguirement of continued participation in the Medicare and Medicaid programs and does not, in any manner, constitute and and isino to the valued of protection duty for eight consecutive hours, seven days a week. This plan of correction is provided as a necessary reguirement of continued participation in the Medicare and Medicaid programs and does not, in any manner, constitute an admission to the valuity of the alleged deficient practice.			345373	B. WING		11	
OCEAN TRAIL HEALTHCARE & REHAB CENTER SOUTHPORT, NC 23461 (M) [D] PHEEIX TAG ISUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MART & PREADED BY FULL RESULATION OF LSC DEMTIFYING INFORMATION) ID PHEEIX TAG PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCIES) (EACH DEFICIENCIES) (EACH DEFICIENCY MART & PREADED BY TAG ID PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MART & PREADED BY TAG PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY) 000 (ID OUT OF LSC DEMTIFYING INFORMATION) PREIX PLAN DEFICIENCY TAG PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY) 000 (ID OUT OF LSC DEMTIFYING INFORMATION) PREIX PLAN DEFICIENCY TAG PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY) 000 (ID OUT OF LSC DEMTIFYING INFORMATION) PREIX PLAN DEFICIENCY TAG PREIX (EACH DEFICIENCY) 000 (ID OUT OF LSC DEMTIFYING INFORMATION) PREIX PLAN DEFICIENCY PREIX PLAN DEFICIENCY PREIX (EACH DEFICIENCY) PREIX (EACH DEFICIENCY) PREIX PLAN DEFICIENCY PREIX PLAN DEFICIENCY PREIX (EACH DEFICIENCY) PREIX PLAN DEFICIENCY PREIX PLAN DEFICIENCY PREIX PLAN DEFICIENCY PREIX (EACH DEFICIENCY) PREIX PLAN DEFICIENCY	NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
PREFIX Tog IEAD DEFICIENCY MUST BE PRECEDED BY FULL REGULTORY OR US CIDENTFYING INFORMATION) PREFX Tog CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE COMPLETING DATE F 279 Continued From page 9 11/18/2015 at 4-50 PM, she indicated the resident leaned to the side, and the bell supported her in the chair. She reported the resident was capable of intentional movements in the chair, She stated the device prevented her from falling out of the chair. The DON stated the expectation was the facility would have used the least restrictive device when indicated and for the device to be care planned. F 354 F 354 483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, SS=F F 354 Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. F 354 Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure a registered nurse was on duty for eight consecutive hours, seven days a week. This plan of correction is provided as a necessary requirement of continued participation in the Medicare and Medicaid protopation in the Wedicare and Medicaid protopation in the Wedicare and Medicaid participation in the weldicidied participation in the weldicidied	OCEAN T	RAIL HEALTHCARE & R	EHAB CENTER				
11/18/2015 at 4:50 PM, she indicated the resident leaned to the side, and the bell supported her in the chair. She reported the resident was capable of intentional movements in the chair, and at times attempted to push herself out of the chair. She stated the device prevented her from falling out of the chair. The DON stated the expectation was the facility would have used the least restrictive device when indicated and for the device to be care planned.F 35412/8/15F 354483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, SS=FF 354F 354F 354Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a restrictive dovice or paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.F 35412/8/15The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.This plan of correction is provided as a necessary requirement of continued participation in the Medicare and Medicaid participation in the Walchare and Medicaid participation in the Walchare and Medicaid participation in the Medicare and Medicaid participation in the Walchare and Medicaid par	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETION
Staffing numbers were reviewed from February All residents are affected by the alleged	F 354	11/18/2015 at 4:50 PI leaned to the side, and the chair. She reported of intentional movement times attempted to put She stated the device out of the chair. The I was the facility would restrictive device when device to be care plan 483.30(b) WAIVER-R FULL-TIME DON Except when waived this section, the facility registered nurse for a a day, 7 days a week Except when waived this section, the facility registered nurse to se nursing on a full time The director of nursin nurse only when the facility facility failed to ensure duty for eight consect week. Findings included:	M, she indicated the resident ad the belt supported her in ed the resident was capable ents in the chair, and at ush herself out of the chair. e prevented her from falling DON stated the expectation have used the least en indicated and for the nned. RN 8 HRS 7 DAYS/WK, under paragraph (c) or (d) of ty must use the services of a at least 8 consecutive hours during the services of a true as the director of basis. If may serve as a charge facility has an average daily ever residents. T is not met as evidenced iew and staff interview, the e a registered nurse was on utive hours, seven days a		necessary requirement of comparticipation in the Medicare a programs and does not, in any constitute an admission to the the alleged deficient practice.	tinued nd Medicaid / manner, validity of	12/8/15
		Staffing numbers wer	e reviewed from February		All residents are affected by th	e alleged	

Event ID: TQLU11

Facility ID: 923382

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED
		345373	B. WING		1	C 1/19/2015
	ROVIDER OR SUPPLIER	EHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 354	2015 through Novem negative findings relative Numerous observation the survey were condi- findings realted to pro- In an interview with the (DON) on 11/19/2019 stated the facility did on duty for 8 consect week. The DON furt the process of provide	aber 17/2015 with no ated to provision of care. ons on all shifts throughout ducted with no negative ovision of care. he facility Director of Nursing 5 at 11:30 AM, the DON not have a registered nurse utive hours, seven days a her stated the facility was in	F 354	 deficient practice. To correct this deficient practice, a Registered N be on duty for eight consecutive seven days a week. Completion Date: 12/07/2015 To assure that the alleged deficient not recur, a Registered Nurse with duty for eight consecutive hours, days a week. Completion Date: 12/07/2015 In order to monitor our performant assure that this solution is sustain DON conducted an in-service for nursing staff in the correct proce follow in the event a scheduled F Nurse is unable to report for the scheduled shift. Completion Date: 12/08/2015 In order to monitor our performant to assure that this solution is sustained to assure that this solution is sust the DON or ADON will community the staffing coordinator on a regulation of an absence. Completion Date: 12/08/2015 	Aurse will hours, ency will II be on seven nce to ned, the all dure to Registered nce and tained, cate with ular basis, ursing	

If continuation sheet Page 11 of 11