STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 01/30/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 166 SS=D	483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES (j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. (j)(3) The facility must make information on how to file a grievance or complaint available to the resident. (j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their	F 166		2/6/17

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

Electronically Signed | 02/06/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 166	Continued From page 1	F 166		

conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;

(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;

(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;

(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;

(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement

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F 166	Continued From page 2 Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to investigate a grievance for 1 of 1 sampled residents (Resident #1) reviewed. Findings included: Resident #1's Quarterly Minimum Data Set (MDS) dated 01/05/17 revealed he was admitted to the facility on 07/07/16 with diagnoses of paraplegia, depression and a cervical spine injury. Resident #1 had short and long term memory problems and was moderately impaired in daily decision making. Resident #1 was incontinent of bowel and bladder. Review of the written Record of Complaint dated 01/18/17 revealed a complaint had been made to the Administrator by telephone in regards to Resident #1. The nature of the complaint had been documented, however, there was no documentation that the complaint had been investigated. The Record of Complaint had been signed by the Administrator on 01/18/17. Review of the Monthly Grievance Log for January 2017 revealed a grievance had been filed on 01/18/17 for Resident #1. The log showed the grievance had been resolved and follow-up was not needed. In an interview on 01/30/17 at 8:55 AM the Director of Nursing (DON) stated she had not been in the facility at the time the complaint had been called in to the Administrator. She indicated	F 166	This plan of correction is provided as a necessary requirement of continued participation in the Medicare and Medicaid program(s), and does not, in any manner, constitute an admission as to the validity of the alleged deficient practice. Resident #1 discharged on 1/31/17. All grievances for last 3 months were reviewed by Social Worker on 2/1/17 to ensure proper follow up had been completed and resolution to the grievance had been met. Staff was inserviced by corporate nurse consultant on 1/31/17 on grievance policy. Social worker will perform random audits weekly on grievances to validate completion and timely resolution. In order to ensure that these solutions are sustained, this plan of correction will integrated into our Quality Assurance program and reviewed by the QA committee at our monthly QA meetings for three months and then quarterly thereafter.	

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F 166	Continued From page 3 she would have been the person to investigate the complaint but she had never received a copy so an investigation was not completed. She indicated it was a problem that the grievance was not investigated. In an interview on 01/30/17 at 9:08 AM the Social Services Director (SSD) stated she was responsible for updating the Monthly Grievance Log. She indicated the process for a grievance was for it to be written up and then given to the department head to be investigated. After investigation the grievance would be given back to the Administrator to sign, and then it would be given to her. She stated that if the Administrator signed the Record of Complaint it usually meant the concern had been resolved so that is what she put on the log. The SSD stated the person who investigated the concern would do the follow-up. In an interview on 01/30/17 at 10:35 AM the Administrator stated the DON had not been in the building at the time the complaint was made. He indicated he signed the complaint because he was the one who documented it and not because it had been resolved. He then gave the Record of Complaint to the SSD but did not give a copy to the DON. He indicated that although he did not give the grievance to the DON she was aware of the issue. The Administrator confirmed the grievance had not been investigated and that it should have been investigated. He indicated that since it had not been investigated it was also not resolved. In an interview on 01/30/17 at 12:16 PM the DON stated it was her expectation that grievances be investigated and resolved and that follow-up be conducted as needed.	F 166	Completion Date 2/6/17	
F 241	483.10(a)(1) DIGNITY AND RESPECT OF	F 241		2/6/17

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F 241 SS=D	Continued From page 4 INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to cover a urinary collection bag for 1 of 1 sampled residents (Resident #4). Findings included: Resident #4's Quarterly Minimum Data Set (MDS) dated 10/28/16 revealed he was re-admitted to the facility on 08/26/16 with diagnoses of neurogenic bladder, anxiety, and depression. Resident #4 had short and long term memory problems and was moderately impaired in daily decision making. Resident #4 had an indwelling urinary catheter. In an observation and attempted interview on 01/29/17 at 1:01 PM Resident #4 was lying in bed next to the window with the right side of the bed in full view of anyone walking past the room. A urinary collection bag with dark yellow urine was hanging from the right side of the bed. A black privacy bag was on the floor underneath the urinary collection bag. Resident #4 did not respond when an attempt at an interview was made. In an observation on 01/29/17 at 4:30 PM Resident #4 was lying in bed next to the window with the right side of the bed in full view of anyone walking past the room. A urinary collection bag with dark yellow urine was hanging from the right side of the bed. A black privacy bag was on the floor underneath the urinary collection bag.	F 241	This plan of correction is provided as a necessary requirement of continued participation in the Medicare and Medicaid program(s), and does not, in any manner, constitute an admission as to the validity of the alleged deficient practice. Resident #4 catheter was placed in a privacy bag by the hall nurse on 1/30/17. An audit of residents with foley catheters was completed on 2/6/17 by the Director of Nursing and each resident was observed to be sure that they had a privacy bag in place. Corporate nurse consultant inserviced the nurses and nursing assistants on dignity with emphasis on covering foley catheter bags on 1/31/17. Audits will be performed by the Director of Nursing and/or Assistant Director of Nursing on making sure privacy bags are properly being used and dignity is being maintained three times a week for four weeks then monthly for four weeks to ensure compliance. In order to ensure that these solutions are	

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F 241	Continued From page 5 In an observation on 01/30/17 at 7:45 AM Resident #4 was lying in bed next to the window with the right side of the bed in full view of anyone walking past the room. A urinary collection bag with dark yellow urine was hanging from the right side of the bed. A black privacy bag was on the floor underneath the urinary collection bag. In an interview on 01/30/17 at 11:24 AM Nurse #1, who was caring for Resident #4 that day, stated she had placed a privacy bag over Resident #4's urinary catheter collection bag at approximately 8:20 AM that morning. She indicated urinary catheter collection bags needed to be covered for resident privacy and dignity. In an interview on 01/30/17 at 11:40 AM Nursing Assistant (NA) #1, who was caring for Resident #4 that day, stated a urinary catheter collection bag should be placed in a privacy bag. She stated she saw Nurse #1 place Resident #4's urinary catheter collection bag in a privacy bag at approximately 8:15 AM that morning. She indicated she had not noticed the urinary collection bag was not covered before then. In an interview on 01/30/17 at 12:16 PM the Director of Nursing (DON) stated it was her expectation that urinary catheter collection bags be covered for resident privacy.	F 241	sustained, this plan of correction will be integrated into our Quality Assurance program and reviewed by the QA committee at our monthly QA meetings for three months and then quarterly thereafter. Completion Date 2/6/17	
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interviews the facility failed to	F 312	This plan of correction is provided as a necessary requirement of continued	2/6/17

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F 312	Continued From page 6 provide a complete bed bath for 1 of 1 sampled residents (Resident #3) whose bath was observed. Findings included: Resident #3's Quarterly Minimum Data Set (MDS) dated 01/02/17 revealed he was readmitted to the facility on 05/29/16 with diagnoses of weakness, heart failure, and right below the knee amputation. Resident #3 was cognitively intact and totally dependent on two persons for bathing. In an observation on 01/30/17 at 10:00 AM Nursing Assistant (NA) #2 and NA #3 began a bed bath for Resident #3. NA #3 proceeded to wash, rinse and pat dry Resident #3's chest, arms and hands. NA #2 washed, rinsed and patted dry Resident #3's perineal area. No attempt or offer was made by either NA to wash Residents #3's upper right leg or his left leg or foot. Dry, peeling skin was noted to Resident #3's left foot. Resident #3 was positioned to the right side and the buttocks and back were washed, rinsed and dried by NA #2. A brief was placed on Resident #3 and he was positioned onto his back. There was again no attempt or offer to wash the legs or foot. A pair of pants was placed on Resident #3. Cream was rubbed on Resident #3's left foot and then a sock was placed on the foot. In an interview on 01/30/17 at 10:30 AM NA #2 stated Resident #3 did not like to have his legs or foot washed. She stated she did not offer to wash his legs or foot because she knew he did not want them to be washed. In an interview on 01/30/17 at 10:56 AM NA #3 stated she had applied cream to Resident #3's foot but had not asked him if he wanted his legs or foot washed. In an interview on 01/30/17 at 11:00 AM Resident #3 stated he had asked for cream to be applied to	F 312	participation in the Medicare and Medicaid program(s), and does not, in any manner, constitute an admission as to the validity of the alleged deficient practice. Nursing Assistant #2 received a counseling for failure to provide adequate care and choices to a resident on 1/31/17 by the Director of Nursing. An audit of the bath schedule was completed by the Assistant Director of Nursing on 2/1/17. The corporate nurse consultant inserviced the nurses and nurse assistants on ADL's and providing choices to residents on 1/31/17. Audits on proper ADL care will be done three times a week for four weeks then monthly for four months by the Director of Nursing and/or assistant director of nursing. In order to ensure that these solutions are sustained, this plan of correction will be integrated into our Quality Assurance program and reviewed by the QA committee at our monthly QA meetings for three months and then quarterly thereafter.	

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F 312	Continued From page 7 his left foot to loosen the dry, flaky skin prior to having his foot washed. He indicated that way, when the aide washed his foot, the dry flaky skin would come off on the washcloth. Resident #3 stated he wanted his legs and foot washed and did not know why the aides did not wash them. In an interview on 01/30/17 at 12:16 PM the Director of Nursing (DON) stated it was her expectation that the entire body be bathed during a bed bath. She stated that even if a resident refused on a daily basis to have a body part washed, the aide still needed to offer each time.	F 312		