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 11/19/2015

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 000	INITIAL COMMENTS No deficiencies cited as a result of complaint investigation event TQLU11 on 11/19/2015.	F 000		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review the facility failed to have a medical justification for a seatbelt restraint for 1 of 1 (resident #29) resident reviewed for restraints. Findings included: Record review indicated resident #29 was admitted to the facility on 11/29/12. The resident ' s cumulative diagnoses included Cerebral Palsy, Intellect Disability, Epilepsy, Anxiety and Scoliosis. The most recent comprehensive assessment dated 1/21/2015 indicated resident required total dependence for dressing, eating, toilet use and personal hygiene. Assessment revealed resident was able to understand others, had slurred or mumbled words, had no problem with short term memory but had memory problem recalling long past. Her normal ability to recall included location of own room, staff names and faces and that she resided in a nursing home. Resident noted to have severe cognitive impairment. The assessment indicated resident had behavioral symptoms that interfered with her care and her participation in activities and social interactions.	F 221	This plan of correction is provided as a necessary requirement of continued participation in the Medicare and Medicaid Programs and does not, in any manner, constitute an admission to the validity of the alleged deficient practice. For the resident found to have been affected by the alleged deficient practice, resident #29, the residents need for assistive devices was reassessed by the Rehab staff. As a result of this assessment, the seatbelt was removed. Completion Date: 12/03/2015 For those residents having the potential to be affected by the same alleged deficient practice, the DON has completed an audit of all residents to determine whether any residents were found with an assistive device that could be considered a restraint. Completion Date: 12/03/2015	12/9/15

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

Electronically Signed | 12/09/2015

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F 221	Continued From page 1 The resident was coded as having no physical restraints in or out of bed. The resident ' s record was reviewed. No restraint evaluation and no documentation of the seat belt was found in the medical records. Resident #29 observations: On 11/16/2015 at 3:00 PM, resident was observed in specialty chair beside Unit 1 nurse ' s station with an abdominal device made from thick canvas type material 12 inches in width around her midsection with 3 inch straps attached to each side of the device, the straps were secured in the back of the chair with a buckle. The resident was observed moving all extremities and crying out at intervals. Several staff members observed talking with resident as they walked past the nurse ' s station. On 11/16/2015 at 5:15 PM resident was observed in specialty chair at same location with the device buckled in back of chair. Resident was noted attempting to move from side to side and wiggling in specialty chair during observation. On 11/17/2015 at 1030 AM resident was observed in specialty chair at same location with the device buckled in back of chair. Resident was noted attempting to move from side to side in specialty chair during observation. On 11/18/2015 at 5:05 PM resident was observed in specialty chair at same location with the device buckled in back of chair. Resident was noted attempting to move from side to side in specialty during each observation. In an interview with the Assistant Director of Nursing on 11/18/2015 at 4:30 PM, she stated resident had the seatbelt in her chair at all times. She reported the seatbelt prevented the resident from intentionally thrusting herself out of the chair. She stated the resident purposefully attempted to get out of the chair, especially if she	F 221	To ensure that the alleged deficient practice does not recur, all nurses and cna's will be in-serviced on restraint use and proper assessment of devices that could be considered a restraint. Additionally, nurses will be in-serviced on updating care plans when a restraint is in place or has been removed. Restraint use will be discussed with the Rehabilitation and clinical team at the weekly PAR (Patients at Risk) meeting. Completion Date: 12/09/2015 In order to monitor our performance and to ensure the solutions are sustained, any resident identified going forward, will be discussed at the weekly PAR meeting with the interdisciplinary team in order to identify the least restrictive devices and to ensure the appropriate documentation is completed. We will integrate this plan of correction into our ongoing Quality Assurance program. The DON will review/audit our compliance weekly for four weeks, then monthly for three months. Completion Date: 12/09/2015 and ongoing.	

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F 221	Continued From page 2 desired to return to bed. She indicated resident was unable to remove the device. In an interview with Director of Nursing on 11/18/2015 at 4:50 PM, she indicated the resident leaned to the side and the belt supported her in the chair. She reported the resident was capable of purposeful and 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. She also indicated the device was discussed with the occupational therapist several months ago and was informed it was not a restraint. Her expectation was for the facility to use the least restrictive device when indicated and for it to be properly evaluated and assessed.	F 221		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence;	F 272		12/9/15

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F 272	Continued From page 3 Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to assess 1 of 1 resident reviewed with a seat belt restraint. (resident #29) Findings included: Record review indicated resident #29 was admitted to the facility on 11/29/12. The resident ' s cumulative diagnoses include Cerebral Palsy, Intellect Disability, Epilepsy, Anxiety and Scoliosis. The most recent comprehensive assessment dated 1/21/2015 indicated resident required total dependence for dressing, eating, toilet use and personal hygiene. The assessment revealed resident was able to understand others, had slurred or mumbled words, had no problem with short term memory but had memory problem recalling long past. Her normal ability to recall included location of own room, staff names and	F 272	This plan of correction is provided as a necessary requirement of continued participation in the Medicare and Medicaid programs, and does not, in any manner, constitute an admission to the validity of the alleged deficient practice. For the resident found to have been affected by the alleged deficient practice, a comprehensive assessment was completed on 12/03/2015. As a result of this assessment, an order was received by the Attending Physician and the seatbelt was removed. Completion Date: 12/03/2015 For those residents having the potential to be affected by the same alleged deficient	

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F 272	Continued From page 4 faces and that she resided in a nursing home. Resident was noted to have severe cognitive impairment. The assessment indicated the resident had behavioral symptoms that interfered with her care and her participation in activities and social interactions. The annual MDS (minimum data set) assessment dated 1/21/2015 indicated the resident did not have any restraints, subsequent quarterly assessments dated 4/9/2015 and 7/6/2015 indicated the resident did not have any restraints. The most recent quarterly assessment dated 9/30/2015 indicated the resident did not have any restraints. On 11/16/2015 at 3:00 PM, the resident was observed in specialty chair beside Unit 1 nurse ' s station with an abdominal device made from thick canvas type material 12 inches in width around her midsection with 3 inch straps attached to each side of the device, the straps were secured in the back of the chair with a buckle. Resident was noted attempting to move from side to side and moving all extremities during observation. On 11/16/2015 at 5:15 PM resident was observed in specialty chair beside Unit 1 nurse ' s station with the device around her midsection and fastened/ buckled in back of chair. Resident was noted attempting to move from side to side and moving all extremities during observation. On 11/17/2015 at 1030 AM resident was observed in specialty chair beside Unit 1 nurse ' s station with the device around her midsection and fastened/ buckled in back of chair. Resident was noted attempting to move from side to side and moving all extremities during observation. On 11/18/2015 at 5:05 PM resident was observed in specialty chair beside Unit 1 nurse ' s station with the device around her midsection and fastened/buckled in back of the chair. Resident was noted attempting to move from side to side	F 272	practice, the MDS nurse has audited 100% of residents assessments, to determine that any restraints or assistive devices have been properly assessed. Completion Date: 12/03/2015 To assure that the alleged deficient practice does not recur, the following measures have been put into place; All nurses and cna's have been in-serviced on restraint use, assessment of devices that could be considered a restraint, and the appropriate assessments of these devices while in place and reassessments when removed. Restraint assessments will be reviewed with the interdisciplinary team at the weekly PAR meetings. Completion Date: 12/09/2015 In order to monitor our performance and to make sure that the solutions are sustained, any resident identified going forward will be discussed and the weekly PAR meeting with the interdisciplinary team in order to identify the least restrictive devices and to ensure the appropriate documentation is completed. We will integrate this plan of correction into our on-going Quality Assurance program. The DON will review/audit our compliance weekly for four weeks then monthly for three months. Completion Date: 12/09/2015	

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F 272	Continued From page 5 and moving all extremities during observation. In an interview with the MDS Nurse on 11/18/2015 at 3:36 PM, she indicated she completed the assessments and recorded the information in the MDS system. She stated she was aware the seatbelt was not coded as a restraint. She did not recall the device being discussed in the resident ' s care plan meeting at any time. She said the seatbelt was there to prevent the resident from falling from the chair, because the resident would thrust herself out of the chair. She indicated the seatbelt had always been on the resident ' s chair, and the resident had never been able to remove the device. In an interview with the Assistant Director of Nursing on 11/18/2015 at 4:30 PM, she stated the seatbelt was in the resident ' s chair at all times. She reported the seatbelt prevented the resident from intentionally thrusting herself out of the chair. She stated the resident purposefully attempted to get out of the chair, especially if she desired to return to bed. She indicated the resident was unable to remove the device. In an interview with the Director of Nursing on 11/18/2015 at 4:50 PM, she indicated the resident leaned to the side, and the belt supported her in the chair. She reported the resident was capable of purposeful and intentional movements in the chair, and at times attempted to push herself out of the chair. She stated the device prevented the resident 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 it to be properly evaluated and assessed.	F 272		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment	F 279		12/9/15

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F 279	Continued From page 6 to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to develop a comprehensive care plan for 1 of 1 resident reviewed with a restraint (Resident # 29). Findings included: Record review indicated Resident #29 was admitted to the facility on 11/29/12. The resident ' s cumulative diagnoses included Intellect Disability, Epilepsy, Anxiety and Scoliosis. The annual Minimum Data Set (MDS) dated 1/21/2015 did not code the resident for restraints. The MDS indicated the resident was totally dependent on staff for dressing, eating, toilet use and personal hygiene. The assessment revealed	F 279	This plan of correction is provided as a necessary requirement of continued participation in the Medicare and Medicaid Program and does not, in any manner, constitute an admission to the validity of the alleged deficient practice. For the resident found to have been affected by the alleged deficient practice, resident #29, an assessment was performed by the Rehabilitation department, and due to her current level of disability, it was determined that the belt was not warranted for the purpose of support. A physicians order was obtained and the belt was removed on 12/03/2015	

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F 279	Continued From page 7 the resident was able to understand others, had slurred or mumbled words, had no problem with short term memory but had long term memory problem. Resident #29 noted to have severe cognitive impairment. The assessment indicated the resident had behavioral symptoms that interfered with her care and her participation in activities and social interactions. The Care Area Assessment (CAA) dated 1/21/2015 regarding falls indicated to proceed to the care plan. Record review revealed the resident ' s Care Plan dated 01/28/15 included the resident was at risk for falls due to history of thrusting herself out of her chair. The approaches for this problem included high back wheel chair with anti-thrust cushion and padded seat belt. A revision to the care plan dated 7/15/15 indicated the high back chair, anti-thrust cushion and the seat belt were discontinued. The care plan dated 10/15/2015 included the specialty chair, and the seatbelt was not addressed. An observation of the resident on 11/16/2015 at 3:00 PM revealed the resident in a specialty chair beside Unit 1 nurse ' s station with an abdominal device made from thick canvas type material 12 inches in width around her midsection with 3 inch straps attached to each side of the device, the straps were secured in the back of the chair with a buckle. The resident moved all extremities and attempted to move from side to side and was unable to. An observation of the resident on 11/16/2015 at 5:15 PM revealed the resident in a specialty chair at Unit 1 nurse ' s station with the device buckled in the back of the chair. The resident moved all extremities and attempted to move from side to side and was unable to. An observation on 11/17/2015 at 10:30 AM revealed the resident in a specialty chair at Unit 1	F 279	Completion Date: 12/03/2015 For those residents having the potential to be affected by the same alleged deficient practice, 100% of residents care plans have been audited by the DON. The care plan for each resident has been modified as appropriate for any device that is, or could be considered a restraint. Completion Date: 12/03/2015 To assure that the alleged deficient practice does not recur, the following measures have been put into place. All nurses and cna's have been in-serviced on restraint use, assessment of devices that could be considered a restraint, comprehensive care plans, and the appropriate assessment of these devices while in place and when discontinued. Any changes required in the Care plan, will be reviewed by the Interdisciplinary team at the weekly PAR (Patients At Risk) meetings. Completion Date: 12/09/2015 In order to monitor our performance and to make sure that these solutions are sustained, any resident identified going forward will be discussed at the weekly PAR meeting with the interdisciplinary team in order to identify any changes in care plans and to ensure the appropriate documentation is completed. We will integrate this plan of correction into our on-going Quality Assurance program. The DON will review/audit our compliance weekly for four weeks and then monthly for three months.	

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F 279	Continued From page 8	F 279	Completion Date: 12/09/2015	

nurse ' s station with the device buckled in the back of the chair. The resident moved all extremities and attempted to move from side to side and was unable to.
An observation on 11/17/2015 at 505 PM revealed the resident in a specialty chair at Unit 1 nurse ' s station with the device buckled in the back of the chair. The resident moved all extremities and attempted to move from side to side and was unable to.
In an interview with the Minimum Data Set (MDS) nurse on 11/18/2015 at 3:36 PM, she indicated she was responsible for the care plans and revisions. She reviewed the Care Plan revision dated 7/15/2015 for resident #29. The MDS nurse stated the seatbelt for the chair had not been discontinued and further stated " it was my mistake that I didn ' t put it back on the care plan " . The MDS nurse indicated there was no care plan for the resident ' s seat belt and did not recall the device being discussed in the resident ' s care plan meeting at any time. The MDS nurse also reported the seatbelt prevented the resident from falling from the chair, because the resident would thrust herself out of the chair. She indicated the seatbelt had always been on the resident ' s chair, and the resident had never been able to remove the device.
In an interview with the Assistant Director of Nursing (ADON) on 11/18/2015 at 4:30 PM, the ADON stated the resident had the seatbelt in the specialty chair at all times. She reported the seatbelt prevented the resident from intentionally thrusting herself out of the chair. The ADON stated the resident attempted to get out of the chair, especially if she desired to return to bed. The ADON also reported the resident was unable to remove the device.
In an interview with the Director of Nursing on

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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 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 279		
F 354 SS=F	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON 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. 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. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. 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. Findings included: Staffing numbers were reviewed from February	F 354	This plan of correction is provided as a necessary requirement of continued participation in the Medicare and Medicaid programs and does not, in any manner, constitute an admission to the validity of the alleged deficient practice. All residents are affected by the alleged	12/8/15

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F 354	Continued From page 10 2015 through November 17/2015 with no negative findings related to provision of care. Numerous observations on all shifts throughout the survey were conducted with no negative findings realted to provision of care. In an interview with the facility Director of Nursing (DON) on 11/19/2015 at 11:30 AM, the DON stated the facility did not have a registered nurse on duty for 8 consecutive hours, seven days a week. The DON further stated the facility was in the process of providing this coverage on weekends but has not yet been successful.	F 354	deficient practice. To correct this alleged deficient practice, a Registered Nurse will be on duty for eight consecutive hours, seven days a week. Completion Date: 12/07/2015 To assure that the alleged deficiency will not recur, a Registered Nurse will be on duty for eight consecutive hours, seven days a week. Completion Date: 12/07/2015 In order to monitor our performance to assure that this solution is sustained, the DON conducted an in-service for all nursing staff in the correct procedure to follow in the event a scheduled Registered Nurse is unable to report for the scheduled shift. Completion Date: 12/08/2015 In order to monitor our performance and to assure that this solution is sustained, the DON or ADON will communicate with the staffing coordinator on a regular basis, to assure required Registered Nursing coverage is in place as well as a procedure to assure coverage, in the event of an absence. Completion Date: 12/08/2015	