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 04/24/2018

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

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F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(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. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(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	F 585		5/4/18

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

Electronically Signed | 05/04/2018

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F 585	Continued From page 1	F 585		

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 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

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F 585	Continued From page 2 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 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 staff interviews and record review the facility failed to provide a written grievance summary for 1 of 1 residents (Resident #1). Findings include: Review of the Minimum Data Set (MDS) dated 01/22/18 revealed Resident #1 was admitted to the facility on 08/27/15 with a diagnosis of cerebral palsy (CP), major depression, overactive bladder, and anxiety. Resident #1 was cognitively intact, was independent with personal hygiene & eating, needed physical help with bathing - limited to transfer & setup only, needed extensive assistance with toilet use, and needed supervision to limited assistance for all other activities of daily living (ADLs). The plan of care for Resident #1 dated 02/1/18 was reviewed with no concerns. Review of the Grievance Log for the three months revealed one grievance had been recorded for	F 585	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F 585 1. Plan for correcting specific deficiency. The process that led to deficiency cited. The facility failed to provide a written resolution and summary to resident #1's father for the grievances dated 04/02/2018.	

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F 585	Continued From page 3 Resident #1's family member. In an interview with the Assistant Director of Nursing (ADON) on 04/23/18 at 12:00 PM she reported that she resolved the resident's family grievance verbally and never provided him with a written resolution and summary to the grievance. She acknowledged the family should have been provided a written resolution and summary, and did not. In an interview with the Director of Nursing (DON) on 04/23/18 at 1:00 PM she reported that the resident's family grievance was resolved verbally and never received a written resolution and summary to the grievance. She acknowledged the family should have been provided a written resolution and summary, and did not. In an interview with the facility Administrator on 04/23/18 at 1:15 PM revealed that the grievance received from Resident #1's family member was resolved verbally. He also said that the facility never provided a written resolution and summary for the grievance to the resident's family member, and should have.	F 585	For Resident # 1, the Assistant Director of Nursing called the Father on 04/04/2018 and verbally responded to the grievance. On 04/23/2018, the Director of Nursing mailed a written resolution and summary to the father of the resident. 2. Procedure for implementing the acceptable plan of correction. On 05/01/2018, the Administrator audited all grievances reports received from 03/01/2018 through 05/01/2018 to identify any grievance that did not indicate that a written resolution and summary was offered and given to the grievant if accepted. On 05/01/2018 in-service education was completed by the Clinical Nurse Consultant to the Administrator, Social Worker, and Director of Nursing and Assistant Director of Nursing on the grievance resolution process. The in-service topics included: • Prompt resolution of all grievances • Facility procedure and time line for addressing grievances • Offering the grievant a written resolution and summary This information has been integrated into the standard orientation training and in the required in-service refresher courses for the above mentioned positions and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.	

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F 585	Continued From page 4	F 585	3. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator will monitor this issue using the Quality Assurance for monitoring grievance resolution. The monitoring will include auditing 100% of all grievances for two weeks to ensure the grievance was promptly addressed and the offering of a written resolution and summary according to facility policy. Then the Administrator will monitor 3 grievances monthly for 3 months for prompt resolution and the offering of a written resolution and summary. Reports will be presented to the weekly Quality Assurance (QA) committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Director of Nursing, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator. 4. The title of the person responsible for implementing the plan of correction. The Administrator is responsible for implementation and completion of the acceptable plan of correction.	