PRINTED: 04/11/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		345343	B. WING		03/28/2018	3
NAME OF PROVIDER OR SUPPLIER  BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO				STREET ADDRESS, CITY, STATE, ZIP CODE 1700 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE COMPLET	TION
F 000	-	onducted a complaint	F 0	00		
F 580	the facility on 3/1/20 to the facility on 3/2 information and exit the exit date was ch Notify of Changes (I	njury/Decline/Room, etc.)	F 5	30	3/28/18	3
SS=G	consult with the resi consistent with his consistent consistent in injury and physician intervention (B) A significant character of the consistent with his consistent in heal status in either life-ticlinical complication (C) A need to alter to a need to discontinuate the treatment due to advocmmence a new for (D) A decision to transident from the fact \$483.15(c)(1)(ii).  (iii) When making not (14)(i) of this section all pertinent informatics available and proviphysician.  (iii) The facility must resident and the resident there is-	fication of Changes. mediately inform the resident; dent's physician; and notify, or her authority, the resident then there is- solving the resident which has the potential for requiring on; onge in the resident's physical, ocial status (that is, a th, mental, or psychosocial fireatening conditions or s); reatment significantly (that is, the an existing form of orm of treatment); or ornsfer or discharge the cility as specified in tification under paragraph (g) orn, the facility must ensure that tion specified in §483.15(c)(2) ovided upon request to the also promptly notify the ident representative, if any,				
ABORATORY	DIRECTOR'S OR PROVIDER	R/SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE	(X6) DATE	

Electronically Signed 03/23/2018

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	345343		B. WING		C 03/28/2018		
NAME OF PI	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/26/2016		
				1700 WAYNE MEMORIAL DRIVE			
BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO				GOLDSBORO, NC 27534			
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			
F 580	as specified in §483. (B) A change in resid State law or regulation (e)(10) of this section (iv) The facility must update the address (phone number of the representative(s). §483.10(g)(15) Admission to a composite of §483.5) must discloss its physical configural locations that compripart, and must specific room changes between under §483.15(c)(9).	n or roommate assignment 10(e)(6); or ent rights under Federal or ons as specified in paragraph in the record and periodically mailing and email) and resident sistenct part. A facility istinct part (as defined in e in its admission agreement tion, including the various se the composite distinct by the policies that apply to en its different locations	F 580				
	by: Based on observation physician interview, a failed to notify the ph pain for one of three (Resident #8) which is experiencing pain fro seventeen days later Findings included:  A review of the medic #8 was admitted 2/8/ pneumonia, hypoxia  The Admission Minim 2/15/2018, noted Res cognition and needed	cal record revealed Resident 2018 with diagnoses of and chronic pain.  num Data Set (MDS) dated sident #8 to be impaired for d extensive assistance for all ing (ADLs), with the physical		F580 - Notify of Changes Preparation and/or execution of this Pl of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set for in the statement of deficiencies. The p of correction is prepared and/or solely because it is required by provision of the Federal & State Law.  1). The plan of correction for the specifi deficiency. The plan should address the process that lead to the deficiency.  a. The Director of Nursing or design will complete an audit of physician orders, facility□s twenty four hour reports and new admission orders for past thirty days to ensure physician notification for residents experiencing	of th lan ne c e		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345343	B. WING		C 03/28/2018
NAME OF PI	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/20/2010
				1700 WAYNE MEMORIAL DRIVE	
BRIAN CE	BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO			GOLDSBORO, NC 27534	
(X4) ID			ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX TAG			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	
F 580	Continued From page	ge 2	F 580	0	
				pain without pain medications ordere	ed
	The care plan for R	esident #8 dated 2/20/2018		and/or patients with unrelieved pain.	
	noted a focus of act			b. The staff re- education will be gi	ven to
	tuberculosis with ve	ertebral destruction, previous		licensed nursing staff on timely phys	cian
	spinal fusion and rh	eumatoid arthritis. The goal		notification for residents experiencing	g pain
	was Resident #8 wo	ould have pain alleviated with		without pain medications ordered an	d/or
		cal and non-pharmacological		patients with unrelieved pain by Dire	
	interventions, with e	evidence of pain relief through		of Nursing and/or Assisted Director	
		n-verbal indicators, such as		Nursing . Any licensed nurse that do	
		g and crying through next		not receive the education will receive	•
		is included: Provide diversion		to working their next scheduled shift.	
		ositioning, television and		Newly hired licensed nurses will rece	
	music. Notify MD of	r unrelieved pain.		the education during new hire orienta	
	0= 0/00/0040 =+ 0.0	20 AM Desident #0		It is alleged the facility failed to notify	/ tne
		30 AM, Resident #8 was		physicians about resident □s pain	
		d, in an interview, stated she er back and legs. Resident #8		(Resident #8) which resulted in the Resident experiencing pain from the	
		o get some pain medication		admission date until seventeen days	lator
	recently and that he	<del>-</del>		2). The procedure for implementing t	
	recently and that he	erped case rier pairi.		acceptable plan of correction for the	
	Δ review of the med	dical record revealed an		specific deficiency cited.	
		assessment for pain dated		a). The staff re- education will be giv	en to
	_	ed Resident #8 stated she had		licensed nursing staff on timely phys	
		e last five days. Resident #8		notification for resident experiencing	
		he worst pain over the last five		pain without pain medications ordered	
		en scale with zero as no pain		and/or patients with unrelieved pain	
		st pain. Resident #8 rated the		Director of Nursing and/or Assisted	
	pain as a five.			Director of Nursing. Any licensed no	ırse
	Nurse #1 was interv	viewed on 3/1/2018 at 10:00		that does not receive the education v	vill
		had done the assessment		receive prior to working their next	
		Resident #8 had stated her		scheduled shift. Newly hired licensed	
		he zero to ten pain scale.		nurses will receive the education dur	ing
		would notify the physician if a		new hire orientation.	
	_	g pain on admission with no		3.) The monitoring procedure to ensu	
		cation. Nurse #1 stated she		that the plan of correction is effective	
		ent #8's physician and could		that specific deficiencies cited remain	
	not remember why.			corrected and/or in compliance with	ne
	0-04/0040 4000	DM in an intensity of MDC		regulatory requirements.	
	On 3/1/2018 at 2:00	PM in an interview, the MDS		a). The Director of Nursing or clinical	ıl

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED C		
			71. 5012511					
		345343	B. WING _			03/28/2018		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO				
DDIAN CE	NTED HEALTH AND	DELIA DIL ITATIONICO I DEDODO		1700 WAYNE MEMORIAL DRIVE				
BRIAN CE	NIER HEALIH AND	REHABILITATION/GOLDSBORO		GOLDSBORO, NC 27534				
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 580	Continued From p	page 3	F t	580				
1 300	nurse stated she is MDS pain intervier 2/22/2018. The N stated a pain lever scale, she told Nurshe did not document in a telephone into Nurse #1 stated sometiment in the state of the stat	nad completed Section J of the w with Resident #8 on urse stated when Resident #8 I of a nine on the zero to ten urse #1. The MDS nurse stated ment telling Nurse #1.  erview on 3/2/2018 at 10:47 AM, he was not informed about a on 2/22/2018.  edication Administration Record evealed an order for Tylenol milligrams (mg) enterally (by s a day for Pain-Severe related thritis, Unspecified back pain.		manager ( unit manager and Director of Nursing) will com audit of physician orders, fa twenty four hour reports and admission orders for the pa to ensure physician notification residents experiencing pain medications ordered and/or unrelieved pain.  b). The Director of Nursing of will review the twenty four hour from the previous day, physifrom previous day and new a orders on new admits from the day, daily, times 4 weeks the times 3 months to ensure physician notification for residents experients with unrelieved pain c). The physician notification report/admission order audit will be reviewed by the facility team weekly times four week monthly times two months an egative findings will be add further education provided a 4) Title of the person responsible implementing the acceptable correction a) The director of nursing an managers will be responsible implementation of the acceptorrection.	plete an acility s new st thirty days on for without pain patients with or designee our report cian orders admission the previous en weekly sysician eriencing pain dered and/or seriencing pain dered and seriencing pain dered and seriencing days of day			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		345343	B. WING		C 03/28/2018	
NAME OF PROVIDER OR SUPPLIER  BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO				STREET ADDRESS, CITY, STATE, ZIP CODE  1700 WAYNE MEMORIAL DRIVE  GOLDSBORO, NC 27534	03/20/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 697 SS=G	Resident #8 would to NA #2 indicated Resident her pain was, and I need somethin would tell the nurse.  NA #3 was interview and stated Resident really hurting but NA remember when tha said where her pain nurse.  Pain Management CFR(s): 483.25(k)  §483.25(k) Pain Mar The facility must ensprovided to residents consistent with profet the comprehensive pand the residents' go This REQUIREMEN by:  Based on observation interview, and record treat a resident's pail assessed for pain (Findings included:  A review of the medial #8 was admitted 2/8 pneumonia, hypoxia.	wed to that hall. NA #2 stated ell her if she was having pain. ident #8 did not say how but would say "I am hurting g for pain." NA #2 stated she ed on 3/28/2018 at 3:40 PM #8 had told NA #3 she was #3 noted she did not toccurred, or if Resident #8 was, and NA #3 got the essional standards of practice, person-centered care plan, pals and preferences. To is not met as evidenced en, resident and staff direview, the facility failed to an for one of three residents resident #8).	F 69		of th lan he	
	cognition and neede	d extensive assistance for all ring (ADLs), with the physical		a. The Director of Nursing or designed will complete an audit of physician	e	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				С			
		345343	B. WING _			03/	28/2018
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DDIAN OF	NITED HEALTH AND DE	UARU ITATIONIONI ROBORO		1	700 WAYNE MEMORIAL DRIVE		
BRIAN CE	NIER HEALIH AND REI	HABILITATION/GOLDSBORO		G	OLDSBORO, NC 27534		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 697	Continued From page	e 5	F 6	597			
F 097	assistance of one to to the care plan for Resonated a focus of actual tuberculosis with vertical spinal fusion and rhead was Resident #8 would both pharmacological interventions, with evolution both verbal and non-regrimacing, groaning a review. Interventions activities such as posmusic. Notify MD of underweather the care indicated Resident #8 hurting in the last five asked to rate her currous scale with zero as no pain. Resident #8 rate. A review of the pain of Medication Administrations.	sident #8 dated 2/20/2018 al pain related to ebral destruction, previous umatoid arthritis. The goal ald have pain alleviated with and non-pharmacological idence of pain relief through verbal indicators, such as and crying through next included: Provide diversion itioning, television and anrelieved pain.  all record revealed a nursing ant dated 2/8/2018 which a stated she had pain or a days. Resident #8 was rent pain on a zero to ten pain and ten as the worst ed the pain as a five.  abservation level in the ation Record (MAR) anted pain levels between	F	697	orders, facility stwenty four hour reports and new admission orders for past thirty days to ensure Residents experiencing pain have pain medication ordered and do not present with unrelieved pain and newly admitted patients with a history of pain have appropriate pain medications ordered. b. The Director of Nursing or designee re-educate facility licensed nursing staf regarding adequate pain management include ensuring Residents experienci pain have pain medications ordered and o not present with unrelieved pain and newly admitted patients with a history opain have appropriate pain medications ordered daily, times 4 weeks then weet times 3 months to ensure physician notification for residents experiencing pain without pain medications ordered and/or patients with unrelieved pain. It is alleged that the facility failed to treatesident spain  2). The procedure for implementing the acceptable plan of correction for the specific deficiency cited. a). The staff re-education will be given licensed nursing staff on timely physicial	will f to ng d d of s kly	
		revealed there was no rdered until 2/25/2018.			notification for resident experiencing pain without pain medications ordered and/or patients with unrelieved pain by		
	observed in bed and her back and legs. Re to get some pain med helped ease her pain				Director of Nursing and/or Assisted Director of Nursing . Any licensed nurs that does not receive the education will receive prior to working their next scheduled shift. Newly hired licensed nurses will receive the education during new hire orientation.	se	
	2/28/2018 at 9:00 AM	member was interviewed on  I. The family member was			3.) The monitoring procedure to ensure		
ORM CMS-2567(02-99) Previous Versions Obsolete Event ID: R1EE11				Fac	cility ID: 922984 If cont	inuation sh	eet Page 6 of 9

OLIVILIY	OT OIL WEDIONILE &	· · · · · · · · · · · · · · · · · · ·				CIVID ITC	7. 0000 0001	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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		345343	B. WING			03/	28/2018	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
BRIAN CE	NTER HEALTH AND REI	HABILITATION/GOLDSBORO			700 WAYNE MEMORIAL DRIVE			
				G	OLDSBORO, NC 27534			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 697	Oxycodone at home of family member stated medication in the host the facility had not give her pain. The family regone to Resident #8's office, obtained a premedication, had the pharmacy and brough member indicated the not give Resident #8 had obtained, took the The family member in because they felt Resfor pain. The family member in the family at 10:00 pain assessment is purse #1 indicated the orders. Nurse #1 note Resident #8 at a five not notify the physicia not remember why should be interested in the family in the physician tremember why should be interested in the family member in the family	was in pain and had taken for an extended time. The I she had received pain pital and did not know why wen Resident #8 anything for member stated they had a regular pain physician's scription for her usual pain prescription filled at a local and it to the facility. The family be were told the facility could the medication the family e medication and kept it. oted the family was upset, sident #8 needed something member said Resident #8 "is 18/2018 at 3:30 PM, the DON) stated she did not lid not get an order for pain pleting the assessment for The DON acknowledged and brought a prescription and the DON had explained to it not use that prescription, ked the prescription in her  AM, Nurse #1 stated if the ositive, I notify the physician. e facility had no standing	F	697	that the plan of correction is effective a that specific deficiencies cited remains corrected and/or in compliance with the regulatory requirements.  a). The Director of Nursing or clinical manager (unit manager and Assisted Director of Nursing) will complete an audit of physician orders, facility stwenty four hour reports and new admission orders for the past thirty day to ensure physician notification for residents experiencing pain without pamedications ordered and/or patients with unrelieved pain. b). The Director of Nursing or designed will review the twenty four hour report from the previous day, physician order from previous day and new admission orders on new admits from the previous day, daily, times 4 weeks then weekly times 3 months to ensure physician notification for residents experiencing pain without pain medications ordered and/or patients with unrelieved pain. c). The physician notification/24 hour report/admission order audit/ audit result will be reviewed by the facility SQAPI team weekly times four weeks then monthly times two months and all negative findings will be addressed and further education provided as needed. 4) Title of the person responsible for implementing the acceptable plan of correction a) The director of nursing and/or unit managers will be responsible for the implementation of the acceptable plan correction.	ys ain the session set the set the set the set the set the session set the set		
		done the Pain Assessment			Correction.			

		X1) PROVIDER/SUPPLIER/CLIA (X2) MUL IDENTIFICATION NUMBER: A. BUILD			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	345343		B. WING			C <b>03/28/2018</b>		
NAME OF PROVIDER OR SUPPLIER  BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO				170	REET ADDRESS, CITY, STATE, ZIP CODE 00 WAYNE MEMORIAL DRIVE DLDSBORO, NC 27534	,		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE	
F 697	on 2/22/2018. The N #8 stated a pain level pain scale, she told I stated she did not do In an interview on 3/ stated Resident #8 h the previous shift on complaints of pain un Resident asked for T #2 stated Resident # to go back to bed an Nurse #1 stated fam Tylenol for Resident was no order and Nu physician. Nurse #2 charge nurse about a Tylenol and an arthri taking, and did phon for Tylenol, which wa A review of the Medi	Section J, with Resident #8 durse stated when Resident el of a nine on the zero to ten Nurse #1. The MDS nurse ocument she told Nurse #1.  1/2018 at 3:30 PM, Nurse #2 and no complaints of pain on 2/25/2018, and had no ntil the evening when fylenol for back pain. Nurse 8 was asked if she would like d Resident #8 refused. ily members asked for #8 and were informed there urse #2 would have to call the stated she conferred with her a contraindication between tis drug Resident #8 was e the physician for an order	F	697				
	2/25/2018 for Tyleno (mg) enterally (by me Pain- Severe related unspecified back pai on 2/25/2018. The pwas a 4 (on a zero to On 3/1/2018 at 5:00 Director of Nursing surses would get an resident was assess ordered.	of Tablet give 650 milligrams buth) three times a day for I to Rheumatoid Arthritis, n. This was given one time ain level listed on the MAR						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345343	B. WING _				28/2018
	NAME OF PROVIDER OR SUPPLIER  BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO				REET ADDRESS, CITY, STATE, ZIP CODE 00 WAYNE MEMORIAL DRIVE DLDSBORO, NC 27534	,	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 697	notify him and he could notify him and he could not 3/28/2018 at 9:40 #1 stated Resident #8 pain. NA #1 stated sh #8 twice and if Reside I got the nurse to ass make faces or anythin having pain.  In an interview on 3/2 stated she had taken the resident had move Resident #8 would te NA #2 indicated Resident #8 would te NA #2 indicated Resident had stated See and Stated Resident #1 really hurting but NA remember when that said where her pain would stated Resident #1 really hurting but NA remember when that said where her pain wourse.  On 3/28/2018 at 3:45 interviewed and stated pain medication and whurting. At that time F	would expect the nurse to all order something.  AM, Nursing Assistant (NA) a could tell you if she had be had worked with Resident ent #8 told me she had pain, ess it. Resident #8 did not hig, she just told me she was as a care of Resident #8 since ed to that hall. NA #2 stated all her if she was having pain. It would say "I am hurting a for pain." NA #2 stated she are done of the state of th	F	697			