STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345343	A. BUILDING _____ B. WING _____	C 03/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO	1700 WAYNE MEMORIAL DRIVE 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The survey team conducted a complaint investigation and revisit on 2/26/2018 and exited the facility on 3/1/2018. The survey team returned to the facility on 3/28/2018 to obtain additional information and exited on 3/28/2018. Therefore the exit date was changed to 3/28/2018. On 4/11/18, the 2567 was amended to add tag F600 at G. The administrator letter was also amended to reflect the new deadlines for submitting the poc and IDR information.	F 000		
F 580 SS=G	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the	F 580		3/28/18

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

Electronically Signed | 03/28/2018

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F 580	Continued From page 1 physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, resident, staff and physician interview, and record review, the facility failed to notify the physician about a resident's pain for one of three residents assessed for pain (Resident #8) which resulted in the Resident experiencing pain from the admission date until seventeen days later. Findings included: A review of the medical record revealed Resident #8 was admitted 2/8/2018 with diagnoses of pneumonia, hypoxia and chronic pain. The Admission Minimum Data Set (MDS) dated	F 580	F580 - Notify of Changes Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. The plan 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 specific deficiency. The plan should address the process that lead to the deficiency. a. The Director of Nursing or designee will complete an audit of physician	

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F 580	Continued From page 2 2/15/2018, noted Resident #8 to be impaired for cognition and needed extensive assistance for all Activities of Daily Living (ADLs), with the physical assistance of one to two persons. The care plan for Resident #8 dated 2/20/2018 noted a focus of actual pain related to tuberculosis with vertebral destruction, previous spinal fusion and rheumatoid arthritis. The goal was Resident #8 would have pain alleviated with both pharmacological and non-pharmacological interventions, with evidence of pain relief through both verbal and non-verbal indicators, such as grimacing, groaning and crying through next review. Interventions included: Provide diversion activities such as positioning, television and music. Notify MD of unrelieved pain. On 2/28/2018 at 8:30 AM, Resident #8 was observed in bed and, in an interview, stated she had some pain in her back and legs. Resident #8 stated she started to get some pain medication recently and that helped ease her pain. A review of the medical record revealed an admission nursing assessment for pain dated 2/8/2018 which noted Resident #8 stated she had pain or hurting in the last five days. Resident #8 was asked to rate the worst pain over the last five days on a zero to ten scale with zero as no pain and ten as the worst pain. Resident #8 rated the pain as a five. Nurse #1 was interviewed on 3/1/2018 at 10:00 AM, and stated she had done the assessment and acknowledged Resident #8 had stated her pain was a five on the zero to ten pain scale. Nurse #1 noted she would notify the physician if a resident was having pain on admission with no order for pain medication. Nurse #1 stated she	F 580	orders, facility□s twenty four hour reports and new admission orders for the past thirty days to ensure physician notification for residents experiencing pain without pain medications ordered and/or patients with unrelieved pain. b. The staff re- education will be given to licensed nursing staff on timely physician notification for residents experiencing pain without pain medications ordered and/or patients with unrelieved pain by Director of Nursing and/or Assisted Director of Nursing . Any licensed nurse 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. It is alleged the facility failed to notify the physicians about resident□s pain (Resident #8) which resulted in the Resident experiencing pain from the admission date until seventeen days later. 2). The procedure for implementing the acceptable plan of correction for the specific deficiency cited. a). The staff re- education will be given to licensed nursing staff on timely physician notification for resident experiencing pain without pain medications ordered and/or patients with unrelieved pain by Director of Nursing and/or Assisted Director of Nursing. Any licensed nurse 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. 3.) The monitoring procedure to ensure that the plan of correction is effective and	

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F 580	Continued From page 3 did not notify Resident #8's physician and could not remember why. On 3/1/2018 at 2:00 PM in an interview, the MDS nurse stated she had completed Section J of the MDS pain interview with Resident #8 on 2/22/2018. The Nurse stated when Resident #8 stated a pain level of a nine on the zero to ten scale, she told Nurse #1. The MDS nurse stated she did not document telling Nurse #1. In a telephone interview on 3/2/2018 at 10:47 AM, Nurse #1 stated she was not informed about Resident #8's pain on 2/22/2018. A review of the Medication Administration Record for Resident #8 revealed an order for Tylenol Tablet Give 650 milligrams (mg) enterally (by mouth) three times a day for Pain-Severe related to Rheumatoid Arthritis, Unspecified back pain. Initiated on 2/25/2018. On 3/1/2018 at 5:00 PM, in an interview, the Director of Nursing stated her expectation was nurses would notify a resident's physician if a resident was assessed for pain and had nothing ordered. In a telephone interview on 3/5/2018 at 2:45 PM, Resident #8's physician stated if the Resident was having pain, he would expect the nurse to notify him and he could order something. On 3/28/2018 at 9:40 AM, Nursing Assistant (NA) #1 stated Resident #8 could tell you if she had pain. NA #1 stated she had worked with Resident #8 twice and if Resident #8 told me she had pain, I got the nurse to assess it. Resident #8 did not make faces or anything, she just told me she was	F 580	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□s twenty four hour reports and new admission orders for the past thirty days to ensure physician notification for residents experiencing pain without pain medications ordered and/or patients with unrelieved pain. b). The Director of Nursing or designee will review the twenty four hour report from the previous day, physician orders 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 results will be reviewed by the facility□s QAPI 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 of correction.	

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F 580	Continued From page 4 having pain. In an interview on 3/28/2018 at 10:15 AM, NA #2 stated she had taken care of Resident #8 since the resident had moved to that hall. NA #2 stated Resident #8 would tell her if she was having pain. NA #2 indicated Resident #8 did not say how much her pain was, but would say "I am hurting and I need something for pain." NA #2 stated she would tell the nurse. NA #3 was interviewed on 3/28/2018 at 3:40 PM and stated Resident #8 had told NA #3 she was really hurting but NA #3 noted she did not remember when that occurred, or if Resident #8 said where her pain was, and NA #3 got the nurse.	F 580		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff	F 600	F600 - Free from Abuse, Neglect, and	4/13/18

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F 600	Continued From page 5 interview, and record review, the facility neglected to treat a resident's pain for one of three residents assessed for pain (Resident #8). Findings included: A review of the medical record revealed Resident #8 was admitted 2/8/2018 with diagnoses of pneumonia, hypoxia and chronic pain. The Admission Minimum Data Set (MDS) dated 2/15/2018, noted Resident #8 to be impaired for cognition and needed extensive assistance for all Activities of Daily Living (ADLs), with the physical assistance of one to two persons. The care plan for Resident #8 dated 2/20/2018 noted a focus of actual pain related to tuberculosis with vertebral destruction, previous spinal fusion and rheumatoid arthritis. The goal was Resident #8 would have pain alleviated with both pharmacological and non-pharmacological interventions, with evidence of pain relief through both verbal and non-verbal indicators, such as grimacing, groaning and crying through next review. Interventions included: Provide diversion activities such as positioning, television and music. Notify MD of unrelieved pain. A review of the medical record revealed a nursing admission assessment dated 2/8/2018 which indicated Resident #8 stated she had pain or hurting in the last five days. Resident #8 was asked to rate her current pain on a zero to ten scale with zero as no pain and ten as the worst pain. Resident #8 rated the pain as a five. A review of the pain observation level in the Medication Administration Record (MAR) revealed six documented pain levels between admission (2/8/2018) and 2/25/2018. A review of the MAR revealed there was no medication for pain ordered until 2/25/2018. On 2/28/2018 at 8:30 AM, Resident #8 was	F 600	Exploitation Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. The plan 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 specific deficiency. The plan should address the process that lead to the deficiency. a. The Director of Nursing or designee will complete pain/Resident interviews on all Residents currently in the facility to ensure any Resident pain concerns are addressed and the Residents are not being neglected due to a lack of pain management. b. The staff re- education will be given to licensed nursing staff on timely pain management and ensuring patients are not subject to abuse and/or neglect from the absence of pain management. Any licensed nurse that does not receive the education prior to the compliance date will receive prior to working their next scheduled shift. Newly hired licensed nurses will receive the education during new hire orientation. It is alleged the (Resident #8) was experiencing pain from the admission date until seventeen days later and this resulted in patient neglect. 2) The procedure for implementing the acceptable plan of correction for the specific deficiency cited. a. The staff re- education will be given to licensed nursing staff on timely pain	

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F 600	Continued From page 6 observed in bed and she stated had some pain in her back and legs. Resident #8 stated she started to get some pain medication recently and that helped ease her pain. Resident #8's family member was interviewed on 2/28/2018 at 9:00 AM. The family member stated Resident #8 had taken pain medication for years, related to her back issues, and saw a local pain physician for her medication. The family member stated she had received pain medication in the hospital and did not know why the facility had not given Resident #8 anything for her pain. The family member stated they had gone to the pain physician's office, obtained a prescription for her usual pain medication, had the prescription filled at a local pharmacy and brought it to the facility. The family member indicated they were told the facility could not give Resident #8 the medication the family had obtained, took the medication and kept it. The family member noted the family was upset, because they felt Resident #8 needed something for pain. The family member said Resident #8 "is my main concern." The resident taken Oxycodone 15 mg to be taken 4 times daily previously. In an interview on 2/28/2018 at 3:30 PM, the Director of Nursing (DON) stated she did not know why Nurse #1 did not get an order for pain medication after completing the assessment for pain for Resident #8. The DON acknowledged Resident #8's family had brought a prescription bottle to the facility and the DON had explained to them the facility could not use that prescription, and the DON had locked the prescription in her office. On 3/1/2018 at 10:00 AM, Nurse #1 stated if the pain assessment is positive, I notify the physician. Nurse #1 indicated the facility had no standing orders. Nurse #1 noted she had assessed	F 600	management and ensuring patients are not neglected from the absence of pain management. Any licensed nurse 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. 3) The monitoring procedure to ensure that the plan of correction is effective and that specific deficiencies cited remains corrected and/or in compliance with the regulatory requirements. a). The Director of Nursing or designee will complete pain assessments and Resident interviews on all Residents currently in the facility to ensure any Resident pain concerns are addressed and the Residents are not being subject to potential abuse and/or neglect due to a lack of pain management. b). The Director of Nursing or designee will complete 3 pain/Resident interviews daily, times 4 weeks then weekly times 3 months to ensure residents are not experiencing pain without adequate pain management and not suffering from potential neglect. c). The Resident pain assessments/interviews audit results will be reviewed by the facility□s QAPI 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	

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F 600	Continued From page 7 Resident #8 at a five on the pain scale and did not notify the physician. Nurse #1 stated she did not remember why she did not call the physician. On 3/1/2018 at 2:00 PM in an interview, the MDS nurse stated she had done the Pain Assessment Interview of the MDS Section J, with Resident #8 on 2/22/2018. The Nurse stated when Resident #8 stated a pain level of a nine on the zero to ten pain scale, she told Nurse #1. The MDS nurse stated she did not document she told Nurse #1. In an interview on 3/1/2018 at 3:30 PM, Nurse #2 stated Resident #8 had no complaints of pain on the previous shift on 2/25/2018, and had no complaints of pain until the evening when Resident asked for Tylenol for back pain. Nurse #2 stated Resident #8 was asked if she would like to go back to bed and Resident #8 refused. Nurse #1 stated family members asked for Tylenol for Resident #8 and were informed there was no order and Nurse #2 would have to call the physician. Nurse #2 stated she conferred with her charge nurse about a contraindication between Tylenol and an arthritis drug Resident #8 was taking, and did phone the physician for an order for Tylenol, which was given at 8:00 PM. A review of the Medication Administration Record (MAR) for Resident #8 revealed an order dated 2/25/2018 for Tylenol Tablet give 650 milligrams (mg) enterally (by mouth) three times a day for Pain- Severe related to Rheumatoid Arthritis, unspecified back pain. This was given one time on 2/25/2018. The pain level listed on the MAR was a 4 (on a zero to ten scale). On 3/1/2018 at 5:00 PM, in an interview, the Director of Nursing stated her expectation was nurses would get an order for pain medication if a resident was assessed for pain and had nothing ordered. In a telephone interview on 3/5/2018 at 2:45 PM,	F 600	implementation of the acceptable plan of correction.	

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F 600	Continued From page 8 Resident #8's physician stated if the Resident was having pain, he would expect the nurse to notify him and he could order something. On 3/28/2018 at 9:40 AM, Nursing Assistant (NA) #1 stated Resident #8 could tell you if she had pain. NA #1 stated she had worked with Resident #8 twice and if Resident #8 told me she had pain, I got the nurse to assess it. Resident #8 did not make faces or anything, she just told me she was having pain. In an interview on 3/28/2018 at 10:15 AM, NA #2 stated she had taken care of Resident #8 since the resident had moved to that hall. NA #2 stated Resident #8 would tell her if she was having pain. NA #2 indicated Resident #8 did not say how much her pain was, but would say "I am hurting and I need something for pain." NA #2 stated she would tell the nurse. NA #3 was interviewed on 3/28/2018 at 3:40 PM and stated Resident #8 had told NA #3 she was really hurting but NA #3 noted she did not remember or if Resident #8 said where her pain was, and NA #3 got the nurse. On 3/28/2018 at 3:45 PM Nurse #3 was interviewed and stated Resident #8 would ask for pain medication and would say that her back was hurting. At that time Resident #8 had an order for pain medication. Nurse #3 indicated no memory of working Resident #8's hall before pain medication was ordered. Although the resident indicated that she was in pain on admission 2/08/18 the facility neglected to obtain medication to treat the pain until 2/25/18.	F 600		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is	F 697		3/28/18

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F 697	Continued From page 9 provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and record review, the facility failed to treat a resident's pain for one of three residents assessed for pain (Resident #8). Findings included: A review of the medical record revealed Resident #8 was admitted 2/8/2018 with diagnoses of pneumonia, hypoxia and chronic pain. The Admission Minimum Data Set (MDS) dated 2/15/2018, noted Resident #8 to be impaired for cognition and needed extensive assistance for all Activities of Daily Living (ADLs), with the physical assistance of one to two persons. The care plan for Resident #8 dated 2/20/2018 noted a focus of actual pain related to tuberculosis with vertebral destruction, previous spinal fusion and rheumatoid arthritis. The goal was Resident #8 would have pain alleviated with both pharmacological and non-pharmacological interventions, with evidence of pain relief through both verbal and non-verbal indicators, such as grimacing, groaning and crying through next review. Interventions included: Provide diversion activities such as positioning, television and music. Notify MD of unrelieved pain. A review of the medical record revealed a nursing admission assessment dated 2/8/2018 which indicated Resident #8 stated she had pain or hurting in the last five days. Resident #8 was	F 697	F697 □Pain Management Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or solely because it is required by provision of the Federal & State Law. 1).The plan of correction the specific deficiency. The plan should address the process that lead to the deficiency a. The Director of Nursing or designee will complete an audit of physician orders, facility□s twenty four hour reports and new admission orders for the past thirty days to ensure Residents experiencing pain have pain medications 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 will re-educate facility licensed nursing staff regarding adequate pain management to include ensuring Residents experiencing pain have pain medications ordered and do not present with unrelieved pain and newly admitted patients with a history of pain have appropriate pain medications ordered daily, times 4 weeks then weekly times 3 months to ensure physician notification for residents experiencing	

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(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 697	Continued From page 10 asked to rate her current pain on a zero to ten scale with zero as no pain and ten as the worst pain. Resident #8 rated the pain as a five. A review of the pain observation level in the Medication Administration Record (MAR) revealed six documented pain levels between admission (2/8/2018) and 2/25/2018. A review of the MAR revealed there was no medication for pain ordered until 2/25/2018. On 2/28/2018 at 8:30 AM, Resident #8 was observed in bed and she stated had some pain in her back and legs. Resident #8 stated she started to get some pain medication recently and that helped ease her pain. Resident #8's family member was interviewed on 2/28/2018 at 9:00 AM. The family member was adamant Resident #8 was in pain and had taken Oxycodone at home for an extended time. The family member stated she had received pain medication in the hospital and did not know why the facility had not given Resident #8 anything for her pain. The family member stated they had gone to Resident #8's regular pain physician's office, obtained a prescription for her usual pain medication, had the prescription filled at a local pharmacy and brought it to the facility. The family member indicated they were told the facility could not give Resident #8 the medication the family had obtained, took the medication and kept it. The family member noted the family was upset, because they felt Resident #8 needed something for pain. The family member said Resident #8 "is my main concern." In an interview on 2/28/2018 at 3:30 PM, the	F 697	pain without pain medications ordered and/or patients with unrelieved pain. It is alleged that the facility failed to treat a resident□s pain 2). The procedure for implementing the acceptable plan of correction for the specific deficiency cited. a). The staff re- education will be given to licensed nursing staff on timely physician notification for resident experiencing pain without pain medications ordered and/or patients with unrelieved pain by Director of Nursing and/or Assisted Director of Nursing . Any licensed nurse 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. 3.) The monitoring procedure to ensure that the plan of correction is effective and 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□s twenty four hour reports and new admission orders for the past thirty days to ensure physician notification for residents experiencing pain without pain medications ordered and/or patients with unrelieved pain. b). The Director of Nursing or designee will review the twenty four hour report from the previous day, physician orders from previous day and new admission orders on new admits from the previous	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345343	A. BUILDING _____ B. WING _____	C 03/28/2018

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F 697	Continued From page 11 Director of Nursing (DON) stated she did not know why Nurse #1 did not get an order for pain medication after completing the assessment for pain for Resident #8. The DON acknowledged Resident #8's family had brought a prescription bottle to the facility and the DON had explained to them the facility could not use that prescription, and the DON had locked the prescription in her office. On 3/1/2018 at 10:00 AM, Nurse #1 stated if the pain assessment is positive, I notify the physician. Nurse #1 indicated the facility had no standing orders. Nurse #1 noted she had assessed Resident #8 at a five on the pain scale and did not notify the physician. Nurse #1 stated she did not remember why she did not call the physician. On 3/1/2018 at 2:00 PM in an interview, the MDS nurse stated she had done the Pain Assessment Interview of the MDS Section J, with Resident #8 on 2/22/2018. The Nurse stated when Resident #8 stated a pain level of a nine on the zero to ten pain scale, she told Nurse #1. The MDS nurse stated she did not document she told Nurse #1. In an interview on 3/1/2018 at 3:30 PM, Nurse #2 stated Resident #8 had no complaints of pain on the previous shift on 2/25/2018, and had no complaints of pain until the evening when Resident asked for Tylenol for back pain. Nurse #2 stated Resident #8 was asked if she would like to go back to bed and Resident #8 refused. Nurse #1 stated family members asked for Tylenol for Resident #8 and were informed there was no order and Nurse #2 would have to call the physician. Nurse #2 stated she conferred with her charge nurse about a contraindication between Tylenol and an arthritis drug Resident #8 was	F 697	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 results will be reviewed by the facility□s QAPI 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 of correction.	

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F 697	Continued From page 12	F 697		

taking, and did phone the physician for an order for Tylenol, which was given at 8:00 PM.

A review of the Medication Administration Record (MAR) for Resident #8 revealed an order dated 2/25/2018 for Tylenol Tablet give 650 milligrams (mg) enterally (by mouth) three times a day for Pain- Severe related to Rheumatoid Arthritis, unspecified back pain. This was given one time on 2/25/2018. The pain level listed on the MAR was a 4 (on a zero to ten scale).

On 3/1/2018 at 5:00 PM, in an interview, the Director of Nursing stated her expectation was nurses would get an order for pain medication if a resident was assessed for pain and had nothing ordered.

In a telephone interview on 3/5/2018 at 2:45 PM, Resident #8's physician stated if the Resident was having pain, he would expect the nurse to notify him and he could order something.

On 3/28/2018 at 9:40 AM, Nursing Assistant (NA) #1 stated Resident #8 could tell you if she had pain. NA #1 stated she had worked with Resident #8 twice and if Resident #8 told me she had pain, I got the nurse to assess it. Resident #8 did not make faces or anything, she just told me she was having pain.

In an interview on 3/28/2018 at 10:15 AM, NA #2 stated she had taken care of Resident #8 since the resident had moved to that hall. NA #2 stated Resident #8 would tell her if she was having pain. NA #2 indicated Resident #8 did not say how much her pain was, but would say "I am hurting and I need something for pain." NA #2 stated she would tell the nurse.

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F 697	Continued From page 13 NA #3 was interviewed on 3/28/2018 at 3:40 PM and stated Resident #8 had told NA #3 she was really hurting but NA #3 noted she did not remember when that occurred, or if Resident #8 said where her pain was, and NA #3 got the nurse. On 3/28/2018 at 3:45 PM Nurse #3 was interviewed and stated Resident #8 would ask for pain medication and would say that her back was hurting. At that time Resident #8 had an order for pain medication. Nurse #3 indicated no memory of working Resident #8's hall before pain medication was ordered.	F 697		