	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING		С
		345343	B. WING		03/28/2018
NAME OF PI	ROVIDER OR SUPPLIER	•	S	IREET ADDRESS, CITY, STATE, ZIP CODE	
		EHABILITATION/GOLDSBORO	17	700 WAYNE MEMORIAL DRIVE	
	NIER HEALIN AND R	ENABLITATION/GOLDSBORD	G	OLDSBORO, NC 27534	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETIC
F 000	INITIAL COMMENT	S	F 000		
F 580 SS=G	investigation and ret the facility on 3/1/20 to the facility on 3/2 information and exit the exit date was ch On 4/11/18, the 256 F600 at G. The adm amended to reflect the submitting the pock Notify of Changes (I CFR(s): 483.10(g)(14) §483.10(g)(14) Notif (i) A facility must imm consult with the resis consistent with his consistent with his consult with the resis consistent with his consult with the resis consult with the resis consistent with his consult with the resis consistent with his consistent with his consult with the resis consistent with his consult with the resis (B) A significant char mental, or psychoso deterioration in heal status in either life-tic clinical complication (C) A need to alter the resis commence a new for (D) A decision to tran resident from the fact §483.15(c)(1)(ii). (ii) When making no (14)(i) of this section all pertinent information	njury/Decline/Room, etc.) 4)(i)-(iv)(15) fication of Changes. mediately inform the resident; dent's physician; and notify, or her authority, the resident hen there is- living the resident which has the potential for requiring on; inge in the resident's physical, ocial status (that is, a th, mental, or psychosocial hreatening conditions or s); reatment significantly (that is, ue an existing form of verse consequences, or to orm of treatment); or insfer or discharge the	F 580		3/28/18

Electronically Signed

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.

03/28/2018

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/01/2018 FORM APPROVED OMB NO. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345343	B. WING		C 03/28/2018
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	•
		HABILITATION/GOLDSBORO		1700 WAYNE MEMORIAL DRIVE	
	NIER HEALTH AND RE	HABILITATION/GOLDSBORG		GOLDSBORO, NC 27534	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 580	resident and the resid when there is- (A) A change in room as specified in §483. ⁷ (B) A change in resid State law or regulatio (e)(10) of this section (iv) The facility must r update the address (r phone number of the representative(s). §483.10(g)(15) Admission to a comp that is a composite di §483.5) must disclose its physical configural locations that compris part, and must specifi room changes betwee under §483.15(c)(9). This REQUIREMENT by: Based on observatio physician interview, a failed to notify the phy pain for one of three f (Resident #8) which r	also promptly notify the lent representative, if any, or roommate assignment 10(e)(6); or ent rights under Federal or ns as specified in paragraph record and periodically mailing and email) and resident osite distinct part. A facility stinct part (as defined in e in its admission agreement tion, including the various se the composite distinct y the policies that apply to en its different locations is not met as evidenced n, resident, staff and and record review, the facility ysician about a resident's residents assessed for pain esulted in the Resident m the admission date until	F 58	F580 - Notify of Changes Preparation and/or execution of this of Correction does not constitute admission by the provider of the trutt facts alleged or the conclusions set f in the statement of deficiencies. The of correction is prepared and/or sole	n of orth 9 plan 9
	#8 was admitted 2/8/2 pneumonia, hypoxia	al record revealed Resident 2018 with diagnoses of and chronic pain. um Data Set (MDS) dated		 because it is required by provision of Federal & State Law. 1).The plan of correction for the spec deficiency. The plan should address process that lead to the deficiency. a. The Director of Nursing or desig will complete an audit of physician 	cific the

Facility ID: 922984

		ID HUMAN SERVICES				FO	ED: 05/01/2018
STATEMENT O	S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		NSTRUCTION	(X3) DA	<u>NO. 0938-0391</u> TE SURVEY MPLETED
		345343	B. WING				C 03/28/2018
NAME OF PI	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		13/20/2010
BRIAN CE	NTER HEALTH AND RE	HABILITATION/GOLDSBORO			DSBORO, NC 27534		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 580	cognition and needed Activities of Daily Livi assistance of one to the The care plan for Res noted a focus of actu- tuberculosis with vert spinal fusion and rher was Resident #8 would both pharmacological interventions, with eve both verbal and non grimacing, groaning a review. Interventions activities such as pos music. Notify MD of u On 2/28/2018 at 8:30 observed in bed and, had some pain in her stated she started to recently and that help A review of the medic admission nursing as 2/8/2018 which noted pain or hurting in the was asked to rate the days on a zero to ten and ten as the worst pain as a five.	sident #8 to be impaired for d extensive assistance for all ng (ADLs), with the physical wo persons. sident #8 dated 2/20/2018 al pain related to ebral destruction, previous umatoid arthritis. The goal ild have pain alleviated with I and non-pharmacological idence of pain relief through verbal indicators, such as and crying through next included: Provide diversion itioning, television and inrelieved pain. AM, Resident #8 was in an interview, stated she back and legs. Resident #8 get some pain medication	F	rr p n p a li n w p o N n tr N tt I p(() F a 2 a s a li n p a L L	prders, facility s twenty four hour eports and new admission orders past thirty days to ensure physiciar potification for residents experience pain without pain medications orde and/or patients with unrelieved pain b. The staff re- education will be censed nursing staff on timely phy potification for residents experienci without pain medications ordered a patients with unrelieved pain by Dir of Nursing and/or Assisted Director Aursing . Any licensed nurse that of the education during new hire orier be working their next scheduled shi Newly hired licensed nurses will re- the education during new hire orier it is alleged the facility failed to not physicians about resident s pain Resident #8) which resulted in the Resident experiencing pain from the admission date until seventeen day correction for resident experiencing paceptable plan of correction for the specific deficiency cited. a). The staff re- education will be g censed nursing staff on timely phy potification for resident experiencing pain without pain medications orde and/or patients with unrelieved pain Director of Nursing and/or Assisted Director of Nursing. Any licensed hat does not receive the education	for the ing red n. given to vsician ng pain ind/or rector or of does ve prior ft. ceive ntation. tify the e vs later. g the e vsician ng red n by vd nurse	
	and acknowledged R pain was a five on the Nurse #1 noted she v resident was having p	ad done the assessment esident #8 had stated her e zero to ten pain scale. vould notify the physician if a pain on admission with no tion. Nurse #1 stated she		s n 3	eceive prior to working their next scheduled shift. Newly hired license nurses will receive the education do new hire orientation. B.) The monitoring procedure to en hat the plan of correction is effective	uring sure	

Facility ID: 922984

	OF DEFICIENCIES	MEDICAID SERVICES	. ,	PLE CONSTRUCTION	(X3) DA	NO. 0938-03 TE SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	CC	MPLETED
		345343	B. WING			C)3/28/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2		13/20/2010
				1700 WAYNE MEMORIAL DRIVE		
	INTER REALTH AND RE	HABILITATION/GOLDSBORO		GOLDSBORO, NC 27534		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETIO DATE
F 580	Continued From page	e 3	F 58	30		
		nt #8's physician and could		that specific deficiencie	s cited remains	
	not remember why.			corrected and/or in con		
				regulatory requirements		
		PM in an interview, the MDS completed Section J of the		a). The Director of Nurs manager (unit manage		
:	MDS pain interview w	-		Director of Nursing) wil		
		e stated when Resident #8		audit of physician orde		
		a nine on the zero to ten		twenty four hour report		
		#1. The MDS nurse stated		admission orders for th		
	she did not documen	t tening Nuise #1.		to ensure physician not residents experiencing		
	In a telephone intervi	ew on 3/2/2018 at 10:47 AM,		medications ordered ar		
		was not informed about		unrelieved pain.		
	Resident #8's pain or	n 2/22/2018.		b). The Director of Nurs will review the twenty for		
	A review of the Medic	ation Administration Record		from the previous day,		
		aled an order for Tylenol		from previous day and		
		rams (mg) enterally (by		orders on new admits f		
		day for Pain-Severe related is, Unspecified back pain.		day, daily, times 4 wee		
	Initiated on 2/25/2018	· · · ·		times 3 months to ensu notification for residents		
				without pain medication		
		PM, in an interview, the		patients with unrelieved	l pain.	
		ated her expectation was		c). The physician notific		
	-	resident's physician if a ed for pain and had nothing		report/admission order will be reviewed by the		
	ordered.	sa ior pair and nad nothing		team weekly times four	-	
				monthly times two mor	nths and all	
		ew on 3/5/2018 at 2:45 PM,		negative findings will be		
		an stated if the Resident would expect the nurse to		further education provid 4) Title of the person re		
	notify him and he cou			implementing the acception		
	On 3/28/2018 at 9:40	AM, Nursing Assistant (NA)		a) The director of nursi	ng and/or unit	
		8 could tell you if she had		managers will be respo	nsible for the	
	· ·	he had worked with Resident		implementation of the a	cceptable plan of	
		ent #8 told me she had pain, ess it. Resident #8 did not		correction.		
		ng, she just told me she was				

Facility ID: 922984

If continuation sheet Page 4 of 14

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345343	B. WING				C 28/2018
NAME OF PF	ROVIDER OR SUPPLIER		•	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER HEALTH AND REI	HABILITATION/GOLDSBORO			00 WAYNE MEMORIAL DRIVE DLDSBORO, NC 27534		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580 F 600 SS=G	stated she had taken the resident had move Resident #8 would tel NA #2 indicated Reside much her pain was, b and I need something would tell the nurse. NA #3 was interviewe and stated Resident # really hurting but NA a remember when that said where her pain w nurse. Free from Abuse and CFR(s): 483.12(a)(1) §483.12 Freedom fro Exploitation The resident has the neglect, misappropria and exploitation as de includes but is not lim corporal punishment, any physical or chem treat the resident's mo §483.12(a)(1) Not use physical abuse, corpor involuntary seclusion;	8/2018 at 10:15 AM, NA #2 care of Resident #8 since ed to that hall. NA #2 stated II her if she was having pain. dent #8 did not say how ut would say "I am hurting of or 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 occurred, or if Resident #8 vas, and NA #3 got the Neglect MAbuse, Neglect, and right to be free from abuse, tion of resident property, efined in this subpart. This ited to freedom from involuntary seclusion and ical restraint not required to edical symptoms. y must- e verbal, mental, sexual, or oral punishment, or	F 5				4/13/18
	by: Based on observatio				F600 - Free from Abuse, Neglect, and	d	

Facility ID: 922984

If continuation sheet Page 5 of 14

TATEMENT (MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		NO. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G	· · ·	OMPLETED
						С
		345343	B. WING			03/28/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI		
				1700 WAYNE MEMORIAL DRIVE		
BRIAN CE	INTER HEALTH AND REI	HABILITATION/GOLDSBORO		GOLDSBORO, NC 27534		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIC DATE
F 600	Continued From page	2 5	F 60	0		
		review, the facility neglected	1.00	Exploitation		
		ain for one of three residents		Preparation and/or exect	ution of this Plan	
	assessed for pain (Re			of Correction does not co		
	Findings included:			admission by the provide		
				facts alleged or the conc		
	A review of the medic	al record revealed Resident		in the statement of defici		
		2018 with diagnoses of		of correction is prepared		
	pneumonia, hypoxia			because it is required by	-	
		um Data Set (MDS) dated		Federal & State Law.		
		sident #8 to be impaired for		1) The plan of correction	for the specific	
		I needed extensive assistance for all deficiency. The plan sho				
	-	ng (ADLs), with the physical		process that lead to the		
	assistance of one to t			a. The Director of Nurs	•	
		sident #8 dated 2/20/2018		will complete pain/Resid		
	noted a focus of actua			all Residents currently in		
		ebral destruction, previous		ensure any Resident pair	•	
	spinal fusion and rhe	umatoid arthritis. The goal		addressed and the Resid	dents are not	
	was Resident #8 wou	Id have pain alleviated with		being neglected due to a	lack of pain	
	both pharmacological	l and non-pharmacological		management.		
	interventions, with ev	idence of pain relief through		b. The staff re- educati	on will be given to	
	both verbal and non-v	verbal indicators, such as		licensed nursing staff on	timely pain	
	grimacing, groaning a	and crying through next		management and ensuri	ng patients are	
	review. Interventions	included: Provide diversion		not subject to abuse and	•	
	activities such as pos	itioning, television and		the absence of pain man	agement. Any	
	music. Notify MD of u	-		licensed nurse that does	not receive the	
		al record revealed a nursing		education prior to the co	•	
		nt dated 2/8/2018 which		receive prior to working t		
		3 stated she had pain or		scheduled shift. Newly hi		
		days. Resident #8 was		nurses will receive the ed	ducation during	
		ent pain on a zero to ten		new hire orientation.		
		pain and ten as the worst		It is alleged the (Reside		
	pain. Resident #8 rate	-		experiencing pain from the		
		observation level in the		date until seventeen day		
	Medication Administra			resulted in patient negled		
		nted pain levels between		2) The procedure for imp		
	admission (2/8/2018)			acceptable plan of correct	ction for the	
		revealed there was no		specific deficiency cited.		
	-	rdered until 2/25/2018.		a. The staff re- educat		
	On 2/28/2018 at 8:30	AW Resident #8 was	1	to licensed nursing staff	on timely nain	1

Facility ID: 922984

If continuation sheet Page 6 of 14

		MEDICAID SERVICES				IO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY
			A. BUILDING	3		С
		345343	B. WING		0	3/28/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		5/20/2010
				1700 WAYNE MEMORIAL DRIVE		
BRIAN CE	INTER HEALTH AND RE	HABILITATION/GOLDSBORO		GOLDSBORO, NC 27534		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETIC
F 600	Continued From page	e 6	F 60	0		
	observed in bed and	she stated had some pain in		management and ensuring pa	itients are	
		esident #8 stated she started		not neglected from the absend		
		dication recently and that		management. Any licensed r		
	helped ease her pain			does not receive the educatio		
	-	member was interviewed on		prior to working their next sch		
		1. The family member stated		Newly hired licensed nurses v		
		n pain medication for years,		the education during new hire		
		sues, and saw a local pain		3) The monitoring procedure		
		lication. The family member /ed pain medication in the		that the plan of correction is e that specific deficiencies cited		
		now why the facility had not		corrected and/or in complianc		
		ything for her pain. The		regulatory requirements.	e with the	
	-	I they had gone to the pain		a). The Director of Nursing or	designee	
	-	tained a prescription for her		will complete pain assessme	-	
	usual pain medication	n, had the prescription filled		Resident interviews on all Res	sidents	
	at a local pharmacy a	and brought it to the facility.		currently in the facility to ensu		
	-	ndicated they were told the		Resident pain concerns are a		
		Resident #8 the medication		and the Residents are not bei		
	-	ed, took the medication and		potential abuse and/or neglec	t due to a	
		ember noted the family was		lack of pain management.		
		felt Resident #8 needed		b). The Director of Nursing or	•	
		he family member said ain concern." The resident		will complete 3 pain/Resident daily, times 4 weeks then weeks		
		mg to be taken 4 times daily		months to ensure residents ar	•	
	previously.			experiencing pain without ade		
		28/2018 at 3:30 PM, the		management and not suffering	•	
		DON) stated she did not		potential neglect.	-	
		lid not get an order for pain		c). The Resident pain		
		pleting the assessment for		assessments/interviews audit		
	-	The DON acknowledged		be reviewed by the facility s		
		had brought a prescription		weekly times four weeks then		
		nd the DON had explained to		times two months and all neg		
		d not use that prescription,		findings will be addressed and		
	office.	ked the prescription in her		education provided as needed4) Title of the person responsi		
		AM, Nurse #1 stated if the		implementing the acceptable		
		ositive, I notify the physician.		correction		
		e facility had no standing		a) The director of nursing and	/or unit	
	orders. Nurse #1 note			managers will be responsible		

Facility ID: 922984

	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION		IO. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:	· /			APLETED
						С
		345343	B. WING		0	3/28/2018
NAME OF PI	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, Z		
				1700 WAYNE MEMORIAL DRIVE		
	NIER NEALTH AND RE	HABILITATION/GOLDSBORO		GOLDSBORO, NC 27534		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICII	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 600	Continued From page	7	F 60	0		
1 000		on the pain scale and did		-	contable plan of	
		•		implementation of the ac	Sceptable plait Of	
	not notify the physician. Nurse #1 stated she did not remember why she did not call the physician.					
		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 wher					
		l of a nine on the zero to ten				
		lurse #1. The MDS nurse				
		cument she told Nurse #1.				
		/2018 at 3:30 PM, Nurse #2				
		ad no complaints of pain on 2/25/2018, and had no				
	complaints of pain un					
		ylenol for back pain. Nurse				
	-	8 was asked if she would like				
	to go back to bed and	d Resident #8 refused.				
		ly members asked for				
		#8 and were informed there				
		rse #2 would have to call the				
		stated she conferred with her				
	-	contraindication between				
	-	is drug Resident #8 was the physician for an order				
	for Tylenol, which wa					
	-	cation Administration Record				
		8 revealed an order dated				
	2/25/2018 for Tylenol	Tablet give 650 milligrams				
		outh) three times a day for				
		to Rheumatoid Arthritis,				
		n. This was given one time				
		in level listed on the MAR				
	was a 4 (on a zero to $Op 3/1/2018$ at 5:00 b					
		PM, in an interview, the acted her expectation was				
	-	order for pain medication if a				
		ed for pain and had nothing				
		a lor pair and had houring				
	ordered.					

Facility ID: 922984

If continuation sheet Page 8 of 14

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		<u>D. 0938-03</u> E SURVEY
D PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	. ,			PLETED
						С
		345343	B. WING		03	/28/2018
IAME OF PI	ROVIDER OR SUPPLIER	•	S	STREET ADDRESS, CITY, STATE, ZIP CO	DE	
			1	700 WAYNE MEMORIAL DRIVE		
	NIER HEALIH AND RE	HABILITATION/GOLDSBORO	GOLDSBORO, NC 27534			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE
F 600	Continued From pag	e 8	F 600			
1 000			F 000			
		ian stated if the Resident would expect the nurse to				
	notify him and he cou					
) AM, Nursing Assistant (NA)				
		8 could tell you if she had				
	pain. NA #1 stated sl	he had worked with Resident				
		lent #8 told me she had pain,				
	•	sess it. Resident #8 did not				
	-	ing, she just told me she was				
	having pain.					
		28/2018 at 10:15 AM, NA #2				
		e care of Resident #8 since ved 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				
	would tell the nurse.					
	NA #3 was interview	ed on 3/28/2018 at 3:40 PM				
	and stated Resident	#8 had told NA #3 she was				
		#3 noted she did not				
		lent #8 said where her pain				
	was, and NA #3 got 1					
	On 3/28/2018 at 3:45	ed Resident #8 would ask for				
		would say that her back was				
		Resident #8 had an order for				
		rse #3 indicated no memory				
	of working Resident					
	medication was orde	-				
	•	t indicated that she was in				
		08/18 the facility neglected to				
		treat the pain until 2/25/18.				
F 697 SS=G	Pain Management CFR(s): 483.25(k)		F 697			3/28/18
	§483.25(k) Pain Man	agement				

Facility ID: 922984

If continuation sheet Page 9 of 14

			000			10.0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	· · ·	TE SURVEY MPLETED
			A. BUILDING			С
		345343	B. WING			3/28/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		3/20/2010
				1700 WAYNE MEMORIAL DRIVE		
BRIAN CE	NTER HEALTH AND RE	HABILITATION/GOLDSBORO				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	COMPLETIC
F 697	Continued From page	e 9	F 697	7		
	provided to residents	who require such services,				
		ssional standards of practice,				
		erson-centered care plan,				
	and the residents' go	-				
	by:	Γ is not met as evidenced				
	Based on observation	on resident and staff		F697 □Pain Management		
		review, the facility failed to		Preparation and/or execution	of this Plan	
		n for one of three residents		of Correction does not constit		
	assessed for pain (Re	esident #8).		admission by the provider of		
	Findings included:			facts alleged or the conclusio		
				in the statement of deficiencie	•	
		cal record revealed Resident 2018 with diagnoses of		of correction is prepared and, because it is required by prov		
	pneumonia, hypoxia	•		Federal & State Law.		
				1).The plan of correction the	specific	
	The Admission Minim	num Data Set (MDS) dated		deficiency. The plan should a		
		sident #8 to be impaired for		process that lead to the defic	•	
		d extensive assistance for all		a. The Director of Nursing or		
		ing (ADLs), with the physical		will complete an audit of phy		
	assistance of one to	two persons.		orders, facility s twenty fou reports and new admission o		
	The care plan for Rev	sident #8 dated 2/20/2018		past thirty days to ensure Res		
	noted a focus of actu			experiencing pain have pain		
		ebral destruction, previous		ordered and do not present w		
		umatoid arthritis. The goal		unrelieved pain and newly ad		
		Id have pain alleviated with		patients with a history of pain		
		l and non-pharmacological		appropriate pain medications		
		idence of pain relief through verbal indicators, such as		b. The Director of Nursing or re-educate facility licensed nu		
		and crying through next		regarding adequate pain mar	-	
		included: Provide diversion		include ensuring Residents	-	
		sitioning, television and		pain have pain medications of		
	music. Notify MD of ι	-		do not present with unrelieve	d pain and	
				newly admitted patients with		
		cal record revealed a nursing		pain have appropriate pain m		
		nt dated 2/8/2018 which		ordered daily, times 4 weeks	•	
	indicated Resident #8	B stated she had pain or	1	times 3 months to ensure ph	ysiciali	

Facility ID: 922984

If continuation sheet Page 10 of 14

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		10. 0938-03 TE SURVEY
ND PLAN OF	CORRECTION	DENTIFICATION NUMBER:		3	CO	MPLETED
						С
		345343	B. WING			3/28/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	ENTER HEALTH AND RE	HABILITATION/GOLDSBORO		1700 WAYNE MEMORIAL DRIVE		
				GOLDSBORO, NC 27534		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 697	Continued From page	e 10	F 69	77		
		rent pain on a zero to ten		pain without pain medications	ordered	
		pain and ten as the worst		and/or patients with unrelieved		
	pain. Resident #8 rate			It is alleged that the facility faile	•	
				resident⊡s pain		
		observation level in the		2). The procedure for impleme		
	Medication Administra			acceptable plan of correction for	or the	
		nted pain levels between		specific deficiency cited.		
	admission (2/8/2018)	and 2/25/2018.		a). The staff re- education will	0	
	A review of the MAR	revealed there was no		licensed nursing staff on timely notification for resident experi		
		rdered until 2/25/2018.		pain without pain medications	-	
				and/or patients with unrelieved		
	On 2/28/2018 at 8:30	AM, Resident #8 was		Director of Nursing and/or As		
		she stated had some pain in		Director of Nursing . Any licen		
		esident #8 stated she started		that does not receive the education		
		dication recently and that		receive prior to working their ne		
	helped ease her pain			scheduled shift. Newly hired lic		
				nurses will receive the education	on during	
		member was interviewed on		new hire orientation.		
		1. The family member was		3.) The monitoring procedure t		
		3 was in pain and had taken		that the plan of correction is eff		
		for an extended time. The d she had received pain		that specific deficiencies cited corrected and/or in compliance		
		spital and did not know why		regulatory requirements.	with the	
		ven Resident #8 anything for		a). The Director of Nursing or	clinical	
		member stated they had		manager (unit manager and A		
		s regular pain physician's		Director of Nursing) will comple		
		scription for her usual pain		audit of physician orders, faci	lity⊡s	
		prescription filled at a local		twenty four hour reports and ne		
		ht it to the facility. The family		admission orders for the past		
		ey were told the facility could		to ensure physician notification		
		the medication the family		residents experiencing pain w		
		e medication and kept it. oted the family was upset,		medications ordered and/or pa unrelieved pain.		
	-	sident #8 needed something		b). The Director of Nursing or c	lesianee	
		nember said Resident #8 "is		will review the twenty four hour		
	my main concern."			from the previous day, physici		
				from previous day and new ad		
	In an interview on 2/2	28/2018 at 3:30 PM, the		orders on new admits from the		

Facility ID: 922984

If continuation sheet Page 11 of 14

		MEDICAID SERVICES				NO. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	· · · ·	OATE SURVEY
	CONTECTION	IDENTIFICATION NOMBER.	A. BUILDING	3		
		245242				С
		345343	B. WING			03/28/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
BRIAN CE	ENTER HEALTH AND RE	HABILITATION/GOLDSBORO		1700 WAYNE MEMORIAL DRIVE		
				GOLDSBORO, NC 27534		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 697	Continued From page	e 11	F 69	70		
		DON) stated she did not	1 00		on wookly	
		did not get an order for pain		day, daily, times 4 weeks th times 3 months to ensure pl		
		pleting the assessment for		notification for residents exp		
		The DON acknowledged		pain without pain medication		
		had brought a prescription		and/or patients with unreliev		
	-	nd the DON had explained to		c). The physician notification		
		d not use that prescription,		report/admission order audit		
	-	ked the prescription in her		will be reviewed by the facilit		
	office.			team weekly times four week	•	
				monthly times two months a		
	On 3/1/2018 at 10:00	AM, Nurse #1 stated if the		negative findings will be add		
		ositive, I notify the physician.		further education provided as		
		e facility had no standing		4) Title of the person respon		
	orders. Nurse #1 note	ed she had assessed		implementing the acceptable	e plan of	
	Resident #8 at a five	on the pain scale and did		correction		
	not notify the physicia	an. Nurse #1 stated she did		a) The director of nursing an	d/or unit	
	not remember why sh	ne did not call the physician.		managers will be responsible implementation of the accep		
	On 3/1/2018 at 2:00 I	PM in an interview, the MDS		correction.		
	nurse stated she had	done the Pain Assessment				
	Interview of the MDS	Section J, with Resident #8				
		urse stated when Resident				
		l of a nine on the zero to ten				
		lurse #1. The MDS nurse				
	stated she did not do	cument she told Nurse #1.				
	In an interview on 3/1	/2018 at 3:30 PM, Nurse #2				
		ad no complaints of pain on				
		2/25/2018, and had no				
	complaints of pain un					
		ylenol for back pain. Nurse				
		8 was asked if she would like				
	to go back to bed and	d Resident #8 refused.				
	•	ly members asked for				
		#8 and were informed there				
		rse #2 would have to call the				
	physician. Nurse #2 s	stated she conferred with her				
		contraindication between				
	Tylenol and an arthrit	is drug Resident #8 was				

If continuation sheet Page 12 of 14

DEPART CENTER		FORM APPROVED OMB NO. 0938-0391						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 03/28/2018		
		345343	B. WING					
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
BRIAN CE	INTER HEALTH AND REI	HABILITATION/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 PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 697	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F	697				
	stated she had taken the resident had mov Resident #8 would te NA #2 indicated Resid much her pain was, b	8/2018 at 10:15 AM, NA #2 care of Resident #8 since ed to that hall. NA #2 stated Il her if she was having pain. dent #8 did not say how but would say "I am hurting g for pain." NA #2 stated she						

If continuation sheet Page 13 of 14

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/01/2018 APPROVED D: 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345343	B. WING			C 03/28/2018		
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/		
BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO				1700 WAYNE MEMORIAL DRIVE				
				G	OLDSBORO, NC 27534			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 697	Continued From page 13		F	697				
	and stated Resident # really hurting but NA remember when that said where her pain v nurse. On 3/28/2018 at 3:45 interviewed and state pain medication and v hurting. At that time F	occurred, or if Resident #8 vas, and NA #3 got the PM Nurse #3 was d Resident #8 would ask for would say that her back was Resident #8 had an order for se #3 indicated no memory #8's hall before pain						

If continuation sheet Page 14 of 14