PRINTED: 05/29/2018 FORM APPROVED OMB NO. 0938-0391

AND DUAN OF CORDECTION		` ′	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED				
		345343	B. WING			C 03/28/2018		
	ROVIDER OR SUPPLIER	HABILITATION/GOLDSBORO		STREET ADDRESS, CITY, STATE 1700 WAYNE MEMORIAL DRIV GOLDSBORO, NC 27534		1 00/20/2010		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BI :D TO THE APPROPRIA ICIENCY)	DATE.		
F 000	the facility on 3/1/20	nducted a complaint isit on 2/26/2018 and exited 18. The survey team returned	FC	00				
F 580 SS=G	information and exite the exit date was cha On 4/11/18, the 2567 F600 at G. The admi amended to reflect the submitting the poc an	was amended to add tag nistrator letter was also ne new deadlines for nd IDR information. njury/Decline/Room, etc.)	F 5	80		3/28/18		
	consult with the resic consistent with his or representative(s) where (A) An accident involves and injury and head to alter the clinical complications (C) A need to alter the aneed to discontinuate treatment due to advice commence a new for (D) A decision to transcript the clinical complications (C) A decision to transcript the clinical complications (C) A need to alter the aneed to discontinuate treatment due to advice commence a new for (D) A decision to transcript the fact §483.15(c)(1)(ii). (ii) When making not (14)(i) of this section all pertinent informations.	nediately inform the resident; dent's physician; and notify, r her authority, the resident en there isving the resident which has the potential for requiring n; nge in the resident's physical, cial status (that is, a h, mental, or psychosocial treatening conditions or s); eatment significantly (that is, e an existing form of terse consequences, or to rm of treatment); or nsfer or discharge the						
LABORATORY	I DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATU	RE	TITLE		(X6) DATE		

Electronically Signed 03/28/2018

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 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		345343	B. WING _			C 03/28/2018
	ROVIDER OR SUPPLIER	EHABILITATION/GOLDSBORO		STREET ADDRESS, CITY, STATE, ZIP CODE 1700 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534	,	0.20.20.10
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SH		(X5) COMPLETION DATE
F 580	resident and the resident there is— (A) A change in roo as specified in §483 (B) A change in resistate law or regulat (e)(10) of this sectic (iv) The facility musupdate the address phone number of the representative(s). §483.10(g)(15) Admission to a commodities a composite §483.5) must disclosite physical configur locations that compipart, and must specific room changes betwonder §483.15(c)(9) This REQUIREMENT by: Based on observation physician interview, failed to notify the pipain for one of three (Resident #8) which experiencing pain from the seventeen days late Findings included: A review of the median seventeen days late Findings included:	t also promptly notify the sident representative, if any, or roommate assignment (a.10(e)(6); or dent rights under Federal or ions as specified in paragraph on. t record and periodically (mailing and email) and e resident posite distinct part. A facility distinct part (as defined in se in its admission agreement ation, including the various rise the composite distinct iffy the policies that apply to een its different locations of the interest of the facility hysician about a resident's e residents assessed for pain a resulted in the Resident om the admission date until er.	F 5	F580 - Notify of Changes Preparation and/or execution of of Correction does not constitute admission by the provider of the facts alleged or the conclusions in the statement of deficiencies. of correction is prepared and/or because it is required by provision Federal & State Law. 1). The plan of correction for the deficiency. The plan should add process that lead to the deficien a. The Director of Nursing or of will complete an audit of physic	truth of set forth The plan solely on of the specific ress the cy.	

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			5				С	
		345343	B. WING _			03/	28/2018	
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
BRIAN CE	NTER HEALTH AND I	REHABILITATION/GOLDSBORO		17	700 WAYNE MEMORIAL DRIVE			
DIVIAN CL	MILK HLALIH AND	KEHABIEHAHON/GOEDSBOKO		G	OLDSBORO, NC 27534			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR 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 580	Continued From pa	age 2	F 5	580				
	-	Resident #8 to be impaired for			orders, facility□s twenty four hour			
		ded extensive assistance for all			reports and new admission orders for	the		
		iving (ADLs), with the physical			past thirty days to ensure physician			
	assistance of one t	- · · · · · · · · · · · · · · · · · · ·			notification for residents experiencing			
		·			pain without pain medications ordered			
		Resident #8 dated 2/20/2018			and/or patients with unrelieved pain.			
		ctual pain related to			b. The staff re- education will be give			
		ertebral destruction, previous			licensed nursing staff on timely physici			
	'	heumatoid arthritis. The goal			notification for residents experiencing p			
		ould have pain alleviated with			without pain medications ordered and/			
		cal and non-pharmacological			patients with unrelieved pain by Director			
		evidence of pain relief through n-verbal indicators, such as			of Nursing and/or Assisted Director of Nursing . Any licensed nurse that does			
		g and crying through next			not receive the education will receive p			
		ns included: Provide diversion			to working their next scheduled shift.	1101		
		positioning, television and			Newly hired licensed nurses will receiv	е		
	music. Notify MD o				the education during new hire orientation			
		·			It is alleged the facility failed to notify t			
	On 2/28/2018 at 8:	30 AM, Resident #8 was			physicians about resident□s pain			
		nd, in an interview, stated she			(Resident #8) which resulted in the			
		ner back and legs. Resident #8			Resident experiencing pain from the			
		to get some pain medication			admission date until seventeen days la			
	recently and that h	elped ease her pain.			2). The procedure for implementing the	;		
	A manufactura of the amount	diant record revealed an			acceptable plan of correction for the			
		dical record revealed an			specific deficiency cited. a). The staff re- education will be given	, to		
		assessment for pain dated ted Resident #8 stated she had			licensed nursing staff on timely physici			
		ne last five days. Resident #8			notification for resident experiencing	ווג		
	ı ·	the worst pain over the last five			pain without pain medications ordered			
		en scale with zero as no pain			and/or patients with unrelieved pain by			
	-	st pain. Resident #8 rated the			Director of Nursing and/or Assisted			
	pain as a five.	•			Director of Nursing. Any licensed nurs	se		
	Nurse #1 was inter	viewed on 3/1/2018 at 10:00			that does not receive the education wil			
	· ·	e had done the assessment			receive prior to working their next			
		Resident #8 had stated her			scheduled shift. Newly hired licensed			
	'	the zero to ten pain scale.			nurses will receive the education during	g		
		e would notify the physician if a			new hire orientation.			
		g pain on admission with no			3.) The monitoring procedure to ensure			
	order for pain med	ication. Nurse #1 stated she			that the plan of correction is effective a	.nd		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345343	B. WING _			1	28/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	
				1700 WAYNE MEMORIAL DRIVE			
BRIAN CE	NIER HEALIH AND REI	HABILITATION/GOLDSBORO		G	GOLDSBORO, NC 27534		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	F 580 Continued From page 3		F t	580			
	not remember why. On 3/1/2018 at 2:00 F	PM in an interview, the MDS completed Section J of the			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		
		e stated when Resident #8			Director of Nursing) will complete an audit of physician orders, facility □s		
	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.				twenty four hour reports and new admission orders for the past thirty da to ensure physician notification for residents experiencing pain without page 1.		
					medications ordered and/or patients wi unrelieved pain. b). The Director of Nursing or designed	ith	
					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 previou day, daily, times 4 weeks then weekly times 3 months to ensure physician notification for residents experiencing particular without pain medications ordered and/or	s pain	
	Director of Nursing st nurses would notify a	t 5:00 PM, in an interview, the rsing stated her expectation was notify a resident's physician if a ssessed for pain and had nothing			patients with unrelieved pain. c). The physician notification/24 hour report/admission order audit/ audit resu will be reviewed by the facility □s QAPI team weekly times four weeks then monthly times two months and all	ults	
	Resident #8's physici	ew on 3/5/2018 at 2:45 PM, an stated if the Resident vould expect the nurse to ld order something.			negative findings will be addressed and further education provided as needed. 4) Title of the person responsible for implementing the acceptable plan of correction	led. or	
	#1 stated Resident #8 pain. NA #1 stated sh #8 twice and if Reside I got the nurse to ass	AM, Nursing Assistant (NA) 3 could tell you if she had e had worked with Resident ent #8 told me she had pain, ess it. Resident #8 did not ng, she just told me she was			a) The director of nursing and/or unit managers will be responsible for the implementation of the acceptable plan correction.	of	

_ ` · · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345343	B. WING		C 03/28/2018	
	ROVIDER OR SUPPLIER	HABILITATION/GOLDSBORO		STREET ADDRESS, CITY, STATE, ZIP CODE 1700 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534	1 00/20/2010	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 600 SS=G	stated she had taken the resident had move Resident #8 would te NA #2 indicated Resimuch her pain was, be and I need something would tell the nurse. NA #3 was interviewed and stated Resident really hurting but NA remember when that said where her pain wourse. Free from Abuse and CFR(s): 483.12(a)(1) §483.12 Freedom from Exploitation The resident has the neglect, misappropriation and exploitation as definitionally incorporal punishment, any physical or chemit treat the resident's missimply sellusion with the sellusion of the	28/2018 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 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 occurred, or if Resident #8 was, and NA #3 got the Neglect M Abuse, Neglect, and right to be free from abuse, ation of resident property, efined in this subpart. This nited to freedom from involuntary seclusion and ical restraint not required to edical symptoms. Ey must- e verbal, mental, sexual, or oral punishment, or	F 58		4/13/18	
	by: Based on observatio	n, resident and staff		F600 - Free from Abuse, Neglect, at	nd	

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345343	B. WING _			C 03/28/2018	
NAME OF P	ROVIDER OR SUPPLIER	1 11 1	1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	20/2010
					700 WAYNE MEMORIAL DRIVE		
BRIAN CE	NTER HEALTH AND RE	HABILITATION/GOLDSBORO			GOLDSBORO, NC 27534		
					, T		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page	e 5	F	300			
		review, the facility neglected			Exploitation		
		ain for one of three residents			Preparation and/or execution of this Pl	an	
	assessed for pain (Re				of Correction does not constitute		
	Findings included:				admission by the provider of the truth of	of	
	· ··································				facts alleged or the conclusions set for		
	A review of the medic	cal record revealed Resident			in the statement of deficiencies. The p		
	#8 was admitted 2/8/	2018 with diagnoses of			of correction is prepared and/or solely		
	pneumonia, hypoxia	and chronic pain.			because it is required by provision of the	ne	
	The Admission Minim	num Data Set (MDS) dated			Federal & State Law.		
		sident #8 to be impaired for			1) The plan of correction for the specifi		
	_	d extensive assistance for all			deficiency. The plan should address th	е	
		ng (ADLs), with the physical			process that lead to the deficiency.		
	assistance of one to				a. The Director of Nursing or design		
	1	sident #8 dated 2/20/2018			will complete pain/Resident interviews	on	
	noted a focus of actu	· · ·			all Residents currently in the facility to	_	
		ebral destruction, previous umatoid arthritis. The goal			ensure any Resident pain concerns are addressed and the Residents are not	<i>;</i>	
		and have pain alleviated with			being neglected due to a lack of pain		
		I and non-pharmacological			management.		
		idence of pain relief through			b. The staff re- education will be give	n to	
		verbal indicators, such as			licensed nursing staff on timely pain		
	I .	and crying through next			management and ensuring patients are	3	
	review. Interventions	included: Provide diversion			not subject to abuse and/or neglect fro	m	
	activities such as pos	itioning, television and			the absence of pain management. Ar	i y	
	music. Notify MD of ι				licensed nurse that does not receive th	е	
		cal record revealed a nursing			education prior to the compliance date	will	
		nt dated 2/8/2018 which			receive prior to working their next		
	I .	3 stated she had pain or			scheduled shift. Newly hired licensed		
	_	days. Resident #8 was			nurses will receive the education during	3	
		rent pain on a zero to ten			new hire orientation.		
	I .	pain and ten as the worst			It is alleged the (Resident #8) was		
	pain. Resident #8 rate				experiencing pain from the admission date until seventeen days later and this		
	Medication Administra	observation level in the			resulted in patient neglect.	,	
	I .	nted pain levels between			2) The procedure for implementing the		
	admission (2/8/2018)	•			acceptable plan of correction for the		
		revealed there was no			specific deficiency cited.		
		rdered until 2/25/2018.			a. The staff re- education will be give	- n	
	1	AM. Resident #8 was			to licensed nursing staff on timely pain		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
				_		,		
		345343	B. WING _				28/2018	
NAME OF P	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	20/2010	
				17	700 WAYNE MEMORIAL DRIVE			
BRIAN CE	NTER HEALTH AND RE	EHABILITATION/GOLDSBORO		G	OLDSBORO, NC 27534			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI) TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 600	Continued From pag	ue 6	F 6	300				
	observed in bed and	she stated had some pain in			management and ensuring patients are	<u>د</u>		
		Resident #8 stated she started			not neglected from the absence of pain			
	_	dication recently and that			management. Any licensed nurse that			
	helped ease her pair				does not receive the education will rece			
		member was interviewed on			prior to working their next scheduled sh	nift.		
	2/28/2018 at 9:00 AM	M. The family member stated			Newly hired licensed nurses will receive	е		
	Resident #8 had take	en pain medication for years,			the education during new hire orientation	on.		
	related to her back is	ssues, and saw a local pain			The monitoring procedure to ensure	ا د		
		dication. The family member			that the plan of correction is effective a			
		ved pain medication in the			that specific deficiencies cited remains			
	T	know why the facility had not			corrected and/or in compliance with the	;		
	_	nything for her pain. The			regulatory requirements.			
	_	d they had gone to the pain			a). The Director of Nursing or designed	Э		
		otained a prescription for her			will complete pain assessments and			
	-	on, had the prescription filled			Resident interviews on all Residents			
		and brought it to the facility. Indicated they were told the			currently in the facility to ensure any Resident pain concerns are addressed			
	-	Resident #8 the medication			and the Residents are not being subject			
		ned, took the medication and			potential abuse and/or neglect due to a			
	_	ember noted the family was			lack of pain management.	·		
		felt Resident #8 needed			b). The Director of Nursing or designee			
		The family member said			will complete 3 pain/Resident interview			
		nain concern." The resident			daily, times 4 weeks then weekly times			
	_	mg to be taken 4 times daily			months to ensure residents are not			
	previously.	-			experiencing pain without adequate pa	in		
		28/2018 at 3:30 PM, the			management and not suffering from			
	Director of Nursing (DON) stated she did not			potential neglect.			
		did not get an order for pain			c). The Resident pain			
		npleting the assessment for			assessments/interviews audit results w			
	•	. The DON acknowledged			be reviewed by the facility□s QAPI tea	m		
		had brought a prescription			weekly times four weeks then monthly			
	_	and the DON had explained to			times two months and all negative			
	_	d not use that prescription,			findings will be addressed and further			
		ad the DON had locked the prescription in her education provided as needed.						
	office.			4) Title of the person responsible for				
		O AM, Nurse #1 stated if the	implementing the acceptable plan of					
		positive, I notify the physician.			correction			
		he facility had no standing ted she had assessed			 a) The director of nursing and/or unit managers will be responsible for the 			
	oracia. Nalac #1 1101	100 3110 1100 0330330U			managera wiii be reaponaible loi tile	ļ		

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						(С
		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		17	700 WAYNE MEMORIAL DRIVE		
DIVIAN OL	INTERTILALITIAND REI	HABIEHAHON/GOEDODONG		G	GOLDSBORO, NC 27534		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B		(X5) COMPLETION
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG	TAG CROSS-REFERENCED TO THE APPROPRIATE			DATE
					DEFICIENCY)		
F 600	Continued From page		F	600			
		on the pain scale and did			implementation of the acceptable plan	of	
		an. Nurse #1 stated she did			correction.		
		ne did not call the physician.					
		PM in an interview, the MDS					
		done the Pain Assessment Section J, with Resident #8					
		urse stated when Resident					
		of a nine on the zero to ten					
		lurse #1. The MDS nurse					
		cument 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						
		2/25/2018, and had no					
	complaints of pain un	til the evening when					
	Resident asked for Ty	lenol for back pain. Nurse					
	#2 stated Resident #8	3 was asked if she would like					
	_	d Resident #8 refused.					
		y 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 was						
	,	eation Administration Record					
		8 revealed an order dated					
	· ,	Tablet give 650 milligrams					
		outh) three times a day for					
	, , , , , , , , , , , , , , , , , , , ,	to Rheumatoid Arthritis,					
	unspecified back pair	n. This was given one time					
		in level listed on the MAR				ĺ	
	was a 4 (on a zero to						
		PM, in an interview, the					
		ated her expectation was				ſ	
		order for pain medication if a					
		ed for pain and had nothing					
	ordered.	0/5/0040					
	In a telephone intervi	ew on 3/5/2018 at 2:45 PM,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345343	B. WING _			1	C 28/2018
	ROVIDER OR SUPPLIER	HABILITATION/GOLDSBORO		1700 W	T ADDRESS, CITY, STATE, ZIP CODE VAYNE MEMORIAL DRIVE SBORO, NC 27534	, 50.	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	was having pain, he notify him and he co On 3/28/2018 at 9:40 #1 stated Resident # pain. NA #1 stated s #8 twice and if Resid I got the nurse to ass make faces or anyth having pain. In an interview on 3/s stated she had taker the resident had more Resident #8 would to NA #2 indicated Resmuch her pain was, and I need somethin would tell the nurse. NA #3 was interview and stated Resident really hurting but NA remember or if Resid was, and NA #3 got On 3/28/2018 at 3:45 interviewed and stated pain medication and hurting. At that time pain medication. Nur of working Resident medication was order	isian stated if the Resident would expect the nurse to uld order something. O AM, Nursing Assistant (NA) is could tell you if she had 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 28/2018 at 10:15 AM, NA #2 in care of Resident #8 since yed 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 led on 3/28/2018 at 3:40 PM #8 had told NA #3 she was #3 noted she did not dent #8 said where her pain the nurse. 5 PM Nurse #3 was led 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 ired.	F	600			
F 697 SS=G	pain on admission 2, obtain medication to Pain Management CFR(s): 483.25(k) §483.25(k) Pain Mar	It indicated that she was in 708/18 the facility neglected to 108/18 the pain until 2/25/18. Inagement. Inagement is 108/19/19/19/19/19/19/19/19/19/19/19/19/19/	F	697			3/28/18

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	LTIPLE CONSTRUCTION DING			(X3) DATE SURVEY COMPLETED	
		345343	B. WING _				28/2018
NAME OF PI	ROVIDER OR SUPPLIER	ı		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	10,10
				17	700 WAYNE MEMORIAL DRIVE		
BRIAN CE	NTER HEALTH AND RE	HABILITATION/GOLDSBORO			OLDSBORO, NC 27534		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	_	(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	ζ	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 697	Continued From page		F 6	697			
		who require such services,					
	· ·	ssional standards of practice,					
		erson-centered care plan,					
	and the residents' go						
		is not met as evidenced					
	by: Based on observatio	n resident and staff			F697 □Pain Management		
		review, the facility failed to			Preparation and/or execution of this Plant	an	
		for one of three residents			of Correction does not constitute	an	
	assessed for pain (Re				admission by the provider of the truth of	of	
	Findings included:				facts alleged or the conclusions set for		
	9				in the statement of deficiencies. The pl		
	A review of the medic	cal record revealed Resident			of correction is prepared and/or solely		
	#8 was admitted 2/8/2	2018 with diagnoses of			because it is required by provision of the	ne	
	pneumonia, hypoxia	and chronic pain.			Federal & State Law.		
					1).The plan of correction the specific		
		num Data Set (MDS) dated			deficiency. The plan should address th	e	
		sident #8 to be impaired for			process that lead to the deficiency		
	_	d extensive assistance for all			a. The Director of Nursing or designed	;	
	· ·	ng (ADLs), with the physical			will complete an audit of physician		
	assistance of one to t	two persons.			orders, facility□s twenty four hour reports and new admission orders for	the	
	The care plan for Res	sident #8 dated 2/20/2018			past thirty days to ensure Residents		
	noted a focus of actua				experiencing pain have pain medicatio	ns	
		ebral destruction, previous			ordered and do not present with		
	'	umatoid arthritis. The goal			unrelieved pain and newly admitted		
		ıld have pain alleviated with			patients with a history of pain have		
		l and non-pharmacological			appropriate pain medications ordered.		
		idence of pain relief through			b. The Director of Nursing or designee		
		verbal indicators, such as			re-educate facility licensed nursing sta		
		and crying through next included: Provide diversion			regarding adequate pain management		
		sitioning, television and			include ensuring Residents experienci pain have pain medications ordered ar	-	
	music. Notify MD of u	<u> </u>			do not present with unrelieved pain and		
	masic. Notify MiD Of t	inionovou pain.			newly admitted patients with a history of		
	A review of the medic	cal record revealed a nursing			pain have appropriate pain medications		
		nt dated 2/8/2018 which			ordered daily, times 4 weeks then wee		
					times 3 months to ensure physician	,	
	indicated Resident #8 stated she had pain or hurting in the last five days. Resident #8 was				notification for residents experiencing		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	EICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345343	B. WING			1	C
NAME OF D	ROVIDER OR SUPPLIER	343343	5:		STREET ADDRESS, CITY, STATE, ZIP CODE	03/	/28/2018
NAME OF PI	ROVIDER OR SUPPLIER						
BRIAN CE	NTER HEALTH AND RE	HABILITATION/GOLDSBORO			700 WAYNE MEMORIAL DRIVE		
				-	GOLDSBORO, NC 27534		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 697	Continued From page	e 10	F	697			
	asked to rate her curi	rent pain on a zero to ten			pain without pain medications ordered		
		pain and ten as the worst			and/or patients with unrelieved pain.		
	pain. Resident #8 rate	ed the pain as a five.			It is alleged that the facility failed to tre resident⊡s pain	at a	
	A review of the pain of	observation level in the			2). The procedure for implementing th	е	
	Medication Administra				acceptable plan of correction for the		
	revealed six docume	nted pain levels between			specific deficiency cited.		
	admission (2/8/2018)	and 2/25/2018.			a). The staff re- education will be given	ı to	
					licensed nursing staff on timely physic	an	
		revealed there was no			notification for resident experiencing		
	medication for pain o	rdered until 2/25/2018.			pain without pain medications ordered		
					and/or patients with unrelieved pain by	1	
		AM, Resident #8 was			Director of Nursing and/or Assisted		
		she stated had some pain in			Director of Nursing . Any licensed nur		
	_	esident #8 stated she started			that does not receive the education wi	d	
		dication recently and that			receive prior to working their next		
	helped ease her pain				scheduled shift. Newly hired licensed nurses will receive the education durin	ı.a	
	Resident #8's family :	member was interviewed on			new hire orientation.	y	
	_	1. The family member was			3.) The monitoring procedure to ensur	e	
		B was in pain and had taken			that the plan of correction is effective a		
		for an extended time. The			that specific deficiencies cited remains		
		d she had received pain			corrected and/or in compliance with th		
		pital and did not know why			regulatory requirements.		
	the facility had not give	ven Resident #8 anything for			a). The Director of Nursing or clinical		
	her pain. The family r	member stated they had			manager (unit manager and Assisted		
	gone to Resident #8's	s regular pain physician's			Director of Nursing) will complete an		
		scription for her usual pain			audit of physician orders, facility□s		
		prescription filled at a local			twenty four hour reports and new		
		ht it to the facility. The family			admission orders for the past thirty da	ı ys	
		ey were told the facility could			to ensure physician notification for	. •	
		the medication the family			residents experiencing pain without p		
		e medication and kept it.			medications ordered and/or patients w	ıtn	
		oted the family was upset,			unrelieved pain.	_	
		sident #8 needed something			b). The Director of Nursing or designe	<i>3</i>	
		nember said Resident #8 "is			will review the twenty four hour report	re	
	my main concern."				from the previous day, physician orde from previous day and new admission		
	In an interview on 2/3	28/2018 at 3:30 PM, the			orders on new admits from the previou		
	in an incrive woll 2/2	-012010 at 3.30 1 1VI, tile	1		Toracia on new aumita nom the previot	13	1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		TE SURVEY MPLETED
		345343	B. WING			C 03/28/2018
NAME OF P	ROVIDER OR SUPPLIER	0.00.0		STREET ADDRESS, CITY, STATE, ZIP COD		13/20/2016
TVAIVIL OF T	TOVIDER OR OUT FEET			1700 WAYNE MEMORIAL DRIVE	_	
BRIAN CE	NTER HEALTH 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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 697	Continued From pag	e 11	F 69	97		
F 697	Director of Nursing (I know why Nurse #1 medication after compain for Resident #8. Resident #8's family bottle to the facility athem the facility coul and the DON had loo office. On 3/1/2018 at 10:00 pain assessment is p. Nurse #1 indicated thorders. Nurse #1 not Resident #8 at a five not notify the physici not remember why s. On 3/1/2018 at 2:00 nurse stated she had Interview of the MDS 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.	DON) stated she did not did not get an order for pain apleting the assessment for. The DON acknowledged had brought a prescription and the DON had explained to d not use that prescription, cked the prescription in her DON acknowledged had brought a prescription and the DON had explained to d not use that prescription in her DON had explained to d not use that prescription in her DON AM, Nurse #1 stated if the positive, I notify the physician. The facility had no standing and she had assessed to on the pain scale and did an. Nurse #1 stated she did he did not call the physician. PM in an interview, the MDS and done the Pain Assessment as Section J, with Resident #8 furse stated when Resident tel of a nine on the zero to ten Nurse #1. The MDS nurse pocument she told Nurse #1. 1/2018 at 3:30 PM, Nurse #2 and no complaints of pain on 2/25/2018, and had no notil the evening when fylenol for back pain. Nurse 88 was asked if she would like d Resident #8 refused. ily members asked for #8 and were informed there	F 69	day, daily, times 4 weeks the times 3 months to ensure phy notification for residents experience pain without pain medications and/or patients with unrelieve c). The physician notification/or report/admission order audit/ will be reviewed by the facility team weekly times four weeks monthly times two months are negative findings will be addressed further education provided as 4) Title of the person respons implementing the acceptable correction a) The director of nursing and managers will be responsible implementation of the acceptate correction.	ysician eriencing ordered d pain. 24 hour audit results S QAPI s then ad all essed and needed. ible for plan of	
	physician. Nurse #2 charge nurse about a	urse #2 would have to call the stated she conferred with her a contraindication between tis drug Resident #8 was				

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 PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO				STREET ADDRESS, CITY, STATE 1700 WAYNE MEMORIAL DRIV GOLDSBORO, NC 27534		33/20/23 10		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	((EACH CORRECTIV CROSS-REFERENCE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 697	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	697				

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 _			03/2	28/2018
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO				STREET ADDRESS, CITY, STATE, ZIP 1700 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534	CODE	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE AC CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 697	and stated Resident really hurting but NA remember when that said where her pain values. On 3/28/2018 at 3:45 interviewed and state pain medication and hurting. At that time F	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 was, and NA #3 got the 5 PM Nurse #3 was ed 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	F	697			