

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515107	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2024
NAME OF PROVIDER OR SUPPLIER United Transitional Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 327 Medical Park Drive Bridgeport, WV 26330	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>50551</p> <p>Based on staff interview and record review, the facility failed to provide the required beneficiary notification for Resident #189. This was true from one (1) of three (3) residents reviewed for beneficiary notices during the long term care survey.</p> <p>Finding include:</p> <p>On 07/02/24 the required Notice of Medicare Non Coverage was requested from the facility for Resident #189 when her most recent medicare stay was ending.</p> <p>On 07/02/24 at 1:30 PM an interview was completed with the Administrator who acknowledged, he could not find a copy of the Beneficiary Notification for Resident #189.</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>39043</p> <p>Based on record review and staff interview, the facility failed to manage pain in accordance with current professional standards of practice. Pain assessments were not consistently performed before and after as needed (PRN) pain medication was given. This deficient practice had the potential to affect one (1) of three (3) residents reviewed for the care area of pain. Resident identifier: #16. Facility census: 26.</p> <p>Findings include:</p> <p>a) Resident #16</p> <p>Review of Resident #16's medical records showed a physician's order written on 06/17/24 for oxycodone (Roxicodone) 5 mg, every six (6) hours as needed for pain.</p> <p>Further medical record review showed three (3) occasions when oxycodone was administered for pain, but no premedication pain assessment was performed. Additionally, the resident was not assessed for effectiveness of the pain medication. These three (3) occasions were as follows:</p> <ul style="list-style-type: none"> - 06/26/24 at 12:54 PM - 06/29/24 at 10:37 PM - 07/30/24 at 9:59 PM <p>Additionally, on 06/29/24 at 3:31 AM, pain effectiveness was assessed after medication administration, but premedication pain assessment was not performed.</p> <p>On 07/03/24 at 9:00 AM, the Director of Nursing (DON) confirmed no premedication or postmedication pain assessments were performed on 06/26/24 at 12:54 PM, 06/29/24 at 10:37 PM, and 07/30/24 at 9:59 PM. Additionally, the DON confirmed no premedication pain assessment was performed on 06/29/24 at 3:31 AM.</p> <p>No further information was provided through the completion of the survey process.</p>