STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515107	A. BUILDING _____ B. WING _____	03/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
UNITED TRANSITIONAL CARE CENTER	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)
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on medical record review and staff interview, the facility failed to develop a comprehensive person centered care plan with nonpharmacological interventions for a resident receiving [MEDICAL CONDITION] medications. This was found for one (1) of five (5) residents reviewed for unnecessary medications. Resident identifier: #10. Facility census: 25. Findings included: a) Resident #10 Review of the medical record on 03/09/20, revealed Resident (R) #10 was receiving [MEDICATION NAME] an antidepressant and [MEDICATION NAME] an anti-anxiety medication daily. The current care plan, with a revision date of 02/25/20, identifies R #10's problem/focus of psychosocial needs, but lacks person centered nonpharmacological interventions. In addition, the care plan fails to identify the use of an antidepressant and/or anti-anxiety medication. Skilled Care Coordinator/Registered Nurse (RN) #60 reviewed R #10's care plan during an interview on 0[DATE] at 8:45 AM. RN #60 confirmed the care plan lacks nonpharmacological interventions and does not identify the use of an antidepressant and anti-anxiety medication. .
F 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on policy review and staff interview, the facility failed to develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the monthly medication regimen review (MRR) process. In addition, the Registered Pharmacist failed to identity and report an irregularity in a resident's MRR. Resident identifier: #10. Facility census: 25. Findings include: a) MRR policy On 03/09/20 at 2:45 PM, review of the facility policy titled Medication Regimen Review with a reviewed date of 09/18 states (typed as written): The Medication Regimen Review (MRR) of each resident must be reviewed at least once a month by a licensed pharmacist . --Paragraph 4. The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing and the reports must be acted upon . This statement is followed by the different steps in the process taken by the pharmacist. --Paragraph 7. Upon completion of the MRR, the facility designee and/or physician will respond to the recommendations within 10 days of the recommendation. --Paragraph 8. If the pharmacist should identify an irregularity and communicates to the facility that it requires urgent action to protect a resident, it will be acted upon immediately, preferably by paging the physician at the time it is discovered . **Except for the identified urgent irregularities, the policy lacks specific time frames for the various steps in the process. After review of the facility MRR policy on 03/09/20 at 03:20 PM, the Administrator verified specific time frames and steps the pharmacist must take if an urgent irregularity is identified is lacking in the policy. He reported, Agree there is nothing in there if the physician does not answer the immediate page. . . b) Resident (R) #10 1) [MEDICAL CONDITION] medication Review of the medical record on 03/09/20, revealed Resident (R) #10 has received the antidepressant [MEDICATION NAME] twice a day since admission. The physician orders written and electronically signed by Medical Doctor (MD) #84 on 02/04/20 includes [MEDICATION NAME] ([MEDICATION NAME] SR) sustained release tablet 150 milligrams (mg) twice a day. The associated [DIAGNOSES REDACTED].#10 but is silent for the [DIAGNOSES REDACTED].#85 prescribed [MEDICATION NAME] ([MEDICATION NAME]) tablet 0.5 mg nightly. The associated [DIAGNOSES REDACTED].#10's medical record but is silent for the [DIAGNOSES REDACTED]. The Director of Nursing (DON) and Registered Pharmacist (RPh) #83 reviewed R #10's medical record during an interview on 03/09/20 at 4:00 PM, and confirmed the MEDICATION ORDERS FOR [REDACTED]. RPh #83 reported MD #84 copies and pastes all of the resident's [DIAGNOSES REDACTED]. The DON and RPh #83 confirmed the [DIAGNOSES REDACTED]. RPh #83 reported the concern with MD #84 not writing the appropriate [DIAGNOSES REDACTED]. RPh #83 acknowledged he was aware MD #84's medication orders lack appropriate [DIAGNOSES REDACTED]. RPh #83 stated he attends the quarterly QAPI meetings and noted he has not brought this concern to the meeting and/or reported it to the Medical Director or facility Administrator. 2) Pain medication Review of the medical record on 03/09/20, revealed Resident (R) #10 was admitted to the facility on [DATE] with [CONDITION] (an infection in the bone). Admission medication orders dated 02/04/20 include the following pain medications: [REDACTED]. [MEDICATION NAME] ([MEDICATION NAME]) 50 mg every six (6) hours as needed for moderate pain (pain scale 4-6). *The orders lack directions for which pain medication to administer. During an interview on 03/09/20 at 3:25 PM, the Director of Nursing (DON) reviewed R #10's medical record and agreed the pain scale parameters for both the [MEDICATION NAME] and the [MEDICATION NAME] are the same. The DON acknowledged there are no directions for staff to utilize in determining which pain medication to administer. At 4:00 PM on 03/09/20, Registered Pharmacist (RPh) #83, agreed the pain scale references were the same for both pain medications and the physician orders lack directions for nursing to utilize when administering the pain medications. In addition, RPh #83, acknowledged he completed medication regimen reviews on R #10 on 02/04/20 and 02/08/20 and did not identify this concern. .
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on medical record review and staff interview, the facility failed to ensure physician orders [REDACTED]. This was true for one (1) of five (5) residents reviewed for unnecessary medications. Resident identifier: #10. Facility census: 25. Findings included: a) Resident #10 Review of the medical record on 03/09/20, revealed Resident (R) #10 has received the antidepressant [MEDICATION NAME] twice a day since admission. The physician orders [REDACTED].#84 on 02/04/20 includes [MEDICATION NAME] ([MEDICATION NAME] SR) sustained release tablet 150 milligrams (mg) twice a day. The associated [DIAGNOSES REDACTED].#10 but is silent for the [DIAGNOSES REDACTED].#85 prescribed [MEDICATION NAME] ([MEDICATION NAME]) tablet 0.5 mg nightly. The associated [DIAGNOSES REDACTED].#10's medical record but is silent for the [DIAGNOSES

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

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.

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F 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) REDACTED].#83 reviewed R #10's medical record during an interview on 03/09/20 at 4:00 PM, and confirmed the MEDICATION ORDERS FOR [REDACTED]. RPh #83 reported MD #84 copies and pastes all of the resident's [DIAGNOSES REDACTED]. The DON and RPh #83 confirmed the [DIAGNOSES REDACTED]. .
F 0867 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based upon record review, staff interview, and policy review, the facility quality assurance committee failed to identify and correct quality deficiencies issues of which they had knowledge or should have had knowledge. The facility failed to develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. The Registered Pharmacist failed to identity and report an irregularity in a resident's MRR. In addition, the facility failed to ensure physician orders [REDACTED]. This practice has the potential to affect all residents. Resident identifier: #10. Facility census: 25. Findings included: a) Cross reference findings at F756 b) Cross reference findings at F758 .