AME OF PROVIDER OR SUPPLIER VARR ACRES NURSING CENTER VARR ACRES NURSING CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (FACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (FACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (FACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (FACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX		F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM	R/CLIA MBER:		PLE CONSTRUCTION G	(X3) DATE SU COMPLE		
EARR ACRES NURSING CENTER 6501 NORTH MACARTHUR OKLAHOMA CITY, OK 73132 (x) (n) ARETX TAG EACH DERICISATION (EACH DERICISATION MINORMATION) PROVIDERS PLAN OF CORRECTION (EACH OBRICETIVE ACTION SHOULD BE CROSS-REFERENCED TO SHOULD BE CROSS-REFERENCED TO DEFICIENCY 00 (EACH OBRICETIVE ACTION SHOULD BE CROSS-REFERENCED TO SHOULD BE CROSS-REFERENCED TO DEFICIENCY 00 (EACH OBRICETIVE ACTION SHOULD BE CROSS-REFERENCED TO SHOULD BE CROSS-REFERENCED TO SHOULD BE CROSS-REFERENCED TO SHOULD BE CROSS-REFERENCED TO DEFICIENCY 00 (EACH OBRICETIVE ACTION SHOULD BE CROSS-REFERENCED TO SHOULD BE CROSS-REFERENCED TO SHOULD BE CROSS-REFERENCED TO SHOULD BE CROSS-REFERENCED TO DEFICIENCY 00 (EACH OBRICETIVE ACTION SHOULD BE CROSS-REFERENCED TO SHOULD BE CROSS-REFERENCED TO DEFICIENCY 00 (EACH OBRICETIVE ACTION SHOULD BE CROSS-REFERENCED TO SHOULD BE CROSS-REFERENCED TO DEFICIENCY 00 (EACH OBRICETIVE ACTION SHOULD BE CROSS-REFERENCED TO SHOULD BE CROSS-REFERENCED TO DEFICIENCY 00 (EACH OBRICETIVE ACTION SHOULD BE CROSS-REFERENCED TO SHOULD BE CROSS-REFERENCED TO Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged nurse must agin and certify that the assessment is completed. F 278 (DATH ACTION OF CROSS-RESENT The Plan Of Correction is prepared and or executed solely because it is required by the provision of federal and state law Resident's # 4 assessment was reviewed and up dated as needed. Resident's # 4 assessment was reviewed and up dated as needed. Resident's # 4 Assessment was reviewed and up dated as needed.<			375275		B. WING			02/04/2016	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR ISC DENTIFYING INFORMATION) PREPEX TAG (EACH CORRECTVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) F 000 INITIAL COMMENTS F 000 INITIAL COMMENTS F 000 On 02/01/16 to 02/04/16 a recertification/relicensure survey was conducted. F 000 SS=D ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. F 278 A registered nurse must conduct or coordinate each assessment with the appropriate perticipation of health professionals. F 000 A registered nurse must sign and certify the accuracy of that portion of the assessment. The Plan Of Correction is prepared and or executed solely because it is required by the provision of federal and state law Each individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment. Staff In-service was done on 03/05/2016 by the DON and designee for the accuracy of assessments and process. Clinical disagreement does not constitute a material and false statement. Continue on next page			ENTER	6501 N	ORTH MA	CARTHUR	!		
 F 278 48.20(g) - (i) ASSESSMENT SS=D ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment. Clinical disagreement does not constitute a material and false statement. Clinical disagreement does not constitute a material and false statement. 	REFIX	(EACH DEFICIENCY MUST	BE PRECEDED BY FULL	REGULATORY	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP	ould be	(X5) COMPLETIO DATE	
 F 278 483.20(g) - (j) ASSESSMENT SS=D A CCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment. Clinical disagreement does not constitute a material and false statement. Clinical disagreement does not constitute a material and false statement. Clinical disagreement does not constitute a material and false statement. Clinical disagreement does not constitute a material and false statement. Clinical disagreement does not constitute a material and false statement. Clinical disagreement does not constitute a material and false statement. Clinical disagreement does not constitute a material and false statement. Clinical disagreement does not constitute a material and false statement. Clinical disagreement does not constitute a material and false statement. Clinical disagreement does not constitute a material and false statement. Clinical disagreement does not constitute a material and false statement. Clinical disagreement does not constitute a material and false statement. Clinical disagreement does not constitute a material and false statement. Clinical disagreement does not constitute a material and false statement. Clinical disagreement does not constitute a material and false statement. Clinical disagreement does not constitute a material	F 000	INITIAL COMMENT	rs		F 000				
 The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment is completed. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment, or an individual who willfully and knowingly causes another individual who assessment. Clinical disagreement does not constitute a material and false statement. 		recertification/relice 483.20(g) - (j) ASS	ensure survey was co ESSMENT		F 278	plan of correction does not	t		
 A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment, or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. 	SS=D	The assessment m				by the provider of the truth facts alleged or conclusior	of the set		
 assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment, or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. Clinical disagreement does not constitute a material and false statement. 	each assessment with the appropriate participation of health professionals.			ordinate		Deficiencies. The Plan Of Correction is	prepared		
 Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment; or an individual who willfully and knowingly causes another individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. Clinical disagreement does not constitute a material and false statement. 		assessment is completed.				required by the provision of			
 willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. Clinical disagreement does not constitute a material and false statement. 	assessment must sign and certify the acc that portion of the assessment. Under Medicare and Medicaid, an individe willfully and knowingly certifies a material false statement in a resident assessment subject to a civil money penalty of not mo \$1,000 for each assessment; or an individe willfully and knowingly causes another ind to certify a material and false statement in resident assessment is subject to a civil m				Resident's # 4 assessmen				
assessment. Clinical disagreement does not constitute a material and false statement.			al and nt is nore than vidual who ndividual t in a I money		has the ability to be affecte alleged practice. Staff In-service was done 03/05/2016 by the DON ar designee for the accuracy	ed by this on nd			
This Requirement is not met as evidenced by:		assessment. Clinical disagreement does not constitute a				process.			
Based on observation, record review, and interview, it was determined the facility failed to ensure assessments were accurately completed for 1 (#4) of 15 sampled residents whose		This Requirement Based on observat interview, it was de ensure assessmen	is not met as eviden ion, record review, a termined <mark>the facility its were accurately c</mark>	nd failed to ompleted			.)		

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.

		AND HUMAN SERV & MEDICAID SERV				FORM	02/08/2016 APPROVED . 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		1	PLE CONSTRUCTION G	(X3) DATE SU COMPLE	
		375275		B. WING 02/04			4/2016
	ROVIDER OR SUPPLIER				STATE, ZIP CODE		
WARR A	CRES NURSING CI	ENTER			CARTHUR Y, OK 73132		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCI T BE PRECEDED BY FULL ENTIFYING INFORMATION)	REGULATORY	id Prefix Tag	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 278	Continued From pa	age 1		F 278	D.O.N. and/or Designee will	do	
	assessments were	reviewed for accura			random audits of assessme		
		egard to the brief int			1-2 times a week to monitor	this	
	89. Findings:	S). The facility cens	us was		process for 4 weeks with re-		
	_				forwarded to the QAPI com		
	Resident #4 had di	agnoses to include d	ementia.				
	The quarterly asser	ssment dated 12/21/	15		for review. Then monthly tin		
					months with results forward		
documented the resident usually made herself understood and usually understood others. The					the QAPI committee for revi	ew.	3.14.16
	assessment asked the question, "Should [BIMS be conducted?" The assessment coded, "No						
	be conducted?" The assessment coded, "No (resident is rarely/never understood)."						
	The care plan last reviewed on 12/31/15 documented the resident was able to make her needs known most of the time.				· · · · · · · · · · · · · · · · · · ·		
	seated in her whee	bserved lying in her Ichair. She was able stions appropriately.				I	
	On 02/02/16 at 10:30 a.m., registered nurse (RN) #1 was shown the assessment and asked the reason the BIMS had not been conducted. She stated the resident did not seem to understand as she mainly spoke Spanish. She stated a Spanish speaking employee had not been requested to help conduct the BIMS. RN #1 was asked if the assessment was accurate in regard to the resident's mental status. She stated the interview should have been attempted.						
F 279 SS=E	483.20(d), 483.20(COMPREHENSIVE	k)(1) DEVELOP E CARE PLANS		F 279	were reviewed and update	•	
		the results of the ass and revise the reside in of care.			needed. Resident residing in the fac behaviors exhibited for the	cility with	
	The facility must de	evelop a comprehens	sive care		administration of anti-psych	notic	
FORM CMS	-2567(02-99) Previous Ve	ersions Obsolete			X4ZB11 I/	continuation st	neet Page 2 of 13

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			1	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		375275		B. WING		02/04	1/2016
	ROVIDER OR SUPPLIER				STATE, ZIP CODE		
WARR A	CRES NURSING CE	ENTER			CARTHUR (, OK 73132		
(X4) ID PREFIX TAG	EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE 18E PRECEDED BY FULL I INTIFYING INFORMATION)	REGULATORY	id Prefix Tag	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 279	plan for each reside objectives and time medical, nursing, a needs that are iden assessment. The care plan must to be furnished to a highest practicable psychosocial well-b §483.25; and any s be required under § due to the resident §483.10, including under §483.10(b)(4) This Requirement Based on observati interview, it was de ensure care plans 5, and #6) of 15 sa plans were reviewe areas not fully deve behaviors exhibited antipsychotic and a facility census was 1. Resident #2 had dementia, major de disorder, and brief The quarterly asses documented the re severely impaired. he had received an the 7 days prior to The behavior/interv	ent that includes meat tables to meet a resi- ind mental and psych tified in the compreh- tified in the compreh- physical, mental, an- being as required und ervices that would of \$483.25 but are not p s exercise of rights u the right to refuse tree the administration and for completeness. eloped were in regard for the administration antianxiety medication 89. Findings: d diagnoses to include apressive disorder, de psychotic disorder. ssment dated 11/26/ sident's cognitive ski The assessment do antipsychotic medic the assessment. rention monthly flow 2016, and 02/2016	ident's losocial lensive es that are resident's d der therwise provided under eatment ced by: nd failed to for 3 (#2, se care The ds to on of ns. The le elusional 15 Ills were cumented cation 7 of	F 279	and anti anxiety drugs have ability to be effected by this practice. Residents receiving anti-ps and anti-anxiety drugs care were reviewed and updated needed. D.O.N. and/or Designee wi random audits of assessme 1-2 times a week to monito process for 4 weeks with re forwarded to the QAPI com for review. Then monthly ti months with results forward the QAPI committee for rev	alleged ychotic -plans d as II do ents r this esults mittee mes 3 led to fiew.	3-14-16 eel Page 3 of 13

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Printed: 02/08/2016 FORM APPROVED OMB NO. 0938-0391

		AND HUMAN SERV & MEDICAID SERV				FORM	MAPPROVED 0. 0938-0391
STATEMEN	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	R/CLIA		PLE CONSTRUCTION	(X3) DATE S COMPL	SURVEY
		375275		B. WING		02/0	04/2016
1	ROVIDER OR SUPPLIER CRES NURSING CI	ENTER	6501 N	ORTH MAG	TATE, ZIP GODE CARTHUR 7, OK 73132	• • • • • • • • • • • • • • • • •	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCI 1 BE PRECEDED BY FULL ENTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	n Should Be E Appropriate	(X5) COMPLETION DATE
F 279	documented the tai included cussing to seeking. The care plan last if documented staff v of the antipsychotic documentation of the resident for the adm The current physical resident was to be antipsychotic media On 02/02/16 the re bed and again in the pleasant. He was a weather. He was a At 2:10 p.m., regist to review the care p behaviors were ide Risperdal. After re stated, "No." 2. Resident #5 had anxiety disorder an A physician's order the administration of anti-anxiety/psychol hours as needed for The quarterly asse documented the re in cognition. The a	reviewed 12/02/15 vere to observe for s medication. There he behaviors exhibited ministration of Risper administered Risper cation) 2 times a day sident was observed he dining room. He w appropriately dressed ble to make his need vered nurse (RN) #1 v olan. She was asked ntified for the admini viewing the care plan d diagnoses that inclu- d dementia.	d exit ide effects was no ed by the dal. nted the dal (an lying in vas d for the ls known. was asked if specific stration of n, she uded umented very 6 sty. 15 impaired nted the	F 279			
	days prior to the as						
L	•					······································	1

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Printed: 02/08/2016

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:			1 · ·	LE CONSTRUCTION	(X3) DATE S COMPL	
	375275			B. WING		02/0	4/2016
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, S	TATE, ZIP CODE		
WARR A					CARTHUR 7, OK 73132		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE F BE PRECEDED BY FULL & INTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	on should be Ie appropriate	(X5) COMPLETION DATE
F 279	resident was at risk medications used fi identify specific beh dosing of psychotro were to attempt to in needs as the cause behaviors prior to m The care plan did m behaviors to warran anti-anxiety. On 02/03/16 at 10:1 was shown the care behaviors for the at were identified on the care plan and states the care plan. 3. Resident #6 had due to a known phy disorder, major dep dementia. The quarterly asses documented the re The assessment de experienced no sig no hallucinations of to the assessment. documented she has antipsychotic medic the assessment. The care plan date resident was at risk psychotropic medic (an antipsychotic medic	a for complications re or anxiety. The staff naviors to warrant as opic medications. The identify environmenta e for changes in moo nedicating as approp not identify the specifi in the administration 00 a.m., the director e plan and asked if the dministration of an ail he care plan. He reveal they were not iden d diagnoses to includ ysiological condition, pressive disorder, and ssment dated 12/02/ sident was cognitivel ocumented the reside ns/symptoms of delir r delusions in the 7 d	were to needed e staff al or basic d and riate. of an of nurses ne nti-anxiety viewed the tified on e delirium anxiety d 15 y intact. ent had rium, and ays prior d an s prior to ted the lated to Abilify e plan e to be	F 279			
	1						haat Baga 6 of 12

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		AND HUMAN SERV & MEDICAID SERV				FORM	02/08/2016 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	375275			B. WING		02/04	/2016
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, S	STATE, ZIP CODE		
WARR A	CRES NURSING CE	ENTER			CARTHUR (, OK 73132		
(X4) ID PREFIX TAG	EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCI BE PRECEDED BY FULL I NTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 279	Continued From pa	age 5		F 279			
	behaviors for which ordered/administer Current physician's	ed. orders documented	the				
	for dementia.	administered Abilify a	at bedtime				
	On 02/02/16 at 11:00 a.m., RN #1 was shown the care plan and asked if the behaviors for which Abilify was ordered were care planned. She reviewed the care plan and stated, "No."						
F 329 SS=E	483.25(I) DRUG REGIMEN IS FREE FROM			F 329	Residents # 2,5 6,9 and #10 reviewed and updated as n		
	unnecessary drugs drug when used in duplicate therapy); without adequate m indications for its us	g regimen must be f . An unnecessary di excessive dose (incl or for excessive dura nonitoring; or without se; or in the presenc	rug is any uding ation; or adequate e of		for their "unnecessary medi Residents residing in the fa the potential to be effected alleged practice In-service was done on med	cility has by this	
		nces which indicate t or discontinued; or a e reasons above.			use and need with the need diagnosis and/or sign/symp	d of	
i i	resident, the facility who have not used	ehensive assessmen must ensure that re antipsychotic drugs	<mark>sidents</mark> are not		avoidance of medication the unnecessary.	at could	
	therapy is necessarias diagnosed and c	unless antipsychotic ry to treat a specific of documented in the cl its who use antipsyc	condition inical		D.O.N. and/or Designee wil random audits of assessme 1-2 times a week to monitor	ents	
	drugs receive gradu behavioral interven	tions, unless clinical an effort to discontin	and y		process for 4 weeks with re forwarded to the QAPI com		
	drugs.		<u></u>		for review. Then monthly ti months with results forward		
					the QAPI committee for rev		3-14-16

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	MENT OF HEALTH					FORM	02/08/2016 APPROVED . 0938-0391
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM			PLE CONSTRUCTION	(X3) DATE \$U COMPLE	
l		375275		8. WING		02/04	4/2016
l	PROVIDER OR SUPPLIER STREET A				TATE, ZIP CODE	····	
WARRA	ACRES NURSING CI	ENTER		ORTH MAG	CARTHUR 7, OK 73132		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCI BE PRECEDED BY FULL NTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	ould be	(X5) COMPLETION DATE
F 329	Continued From pa	age 6		F 329			
	Based on observati interview, it was de ensure unnecessar 9, and #10) of 15 st clinical records wer medication. The un in regard to a urinal diagnoses and mor antianxiety and anti facility census was 1. Resident #6 had due to a known phy disorder, major dep dementia. The quarterly assess documented the res The assessment do experienced no sig and no hallucination prior to the assess antipsychotic medic the assessment. The care plan dated resident was at risk psychotropic medic (an antipsychotic medic	I diagnoses to includ visiological condition, pressive disorder, an assment dated 12/02/ sident was cognitivel ocumented the resident ns/symptoms (s/s) of ns or delusions in the nent. The assessme ad been administered ation 7 of the 7 days d 12/08/15 document for complications re- vation which included redication). The card ecific behaviors were rranted as needed do mentation to indicated Abilify was	nd failed to failed to #2, 5, 6, ose cessary ons were I), related to n. The e delirium anxiety d 15 ly intact. ent had f delirium, e 7 days ent d an s prior to ted the lated to I Abilify e plan e to be osing.				

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	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		375275		B. WING		02/04	/2016
	ROVIDER OR SUPPLIER	·····			STATE, ZIP CODE	I	
WARR A	CRES NURSING CI	ENTER			CARTHUR Y, OK 73132		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCI I BE PRECEDED BY FULL INTIFYING INFORMATION)	REGULATORY	id Prefix Tag	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	OR LSC IDE Continued From pa Current physician's resident was to be for dementia. The behavior/interv 12/2015 documenter for yelling and insor The behavior/interv 01/2016 did not ide monitored. The flor effects] only " and of medication monitor On 02/02/16 at 11:0 (DON) was asked in diagnosis for the ad stated, "No." He w record and asked in which an antipsych be administered. H if a behavior flow re Abilify had been co stated he could not 2. Resident #2 had delusional disorder The quarterly asses documented the re daily decision makit The assessment de antipsychotic media	ATTIFYING INFORMATION) age 7 orders documented administered Ability a vention flow record da ed the resident was a mnia. vention flow record da intify behaviors to be w record documented did not identify Abilify red. 00 a.m., the director f dementia was an a dministration of Abilif as shown the behav f yelling was a behav otic (Abilify) medicat le stated, "No." He we ecord for the monitor mpleted for 01/2016	the at bedtime ated monitored ated d "[side/ as a of nurses ppropriate y. He ior flow ior for ion should was asked ing of . He le disorder. 15 ills for paired. aceived an		CROSS-REFERENCED TO THE APPR		DATE
	documented the st effects of antipsych no documentation	reviewed on 12/2/15 aff were to monitor fo notic medications. T to indicate the signs/ e resident exhibited.	here was				
FORM CMS	-2567(02-99) Previous Ve	ersions Obsolete			X4ZB11	continuation sh	eet Page 8 of 13

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		AND HUMAN SERV & MEDICAID SERV				FOR	MAPPROVED 0. 0938-0391	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM			LE CONSTRUCTION	(X3) DATE S COMPL		
		375275		B. WING 02/04/2				
	ROVIDER OR SUPPLIER CRES NURSING CI	ENTER	6501 N	ORESS, CITY, ST ORTH MAC IOMA CITY		4		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUSI	ATEMENT OF DEFICIENCI T BE PRECEDED BY FULL ENTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 329	Continued From pa	age 8		F 329				
	dated 12/2015, 01/2 documented the be cussing to staff and The current physici resident was to be antipsychotic medic delusions. The resident was o the survey lying in I The resident did no by the survey lying in I The resident did no by the survey or. On 02/02/16 at 2:11 #1 was asked to re intervention month the documents, she behaviors/delusion stated, "There is no 3. Resident #10 ha disorder. The quarterly asses documented the re daily decision maki assessment. The care plan last documented the re mood/behaviors. T monitored included verbally abusive to	ehaviors to be monitod d others, and exit see ian's orders documen administered Risper- cation) 2 times a day observed multiple tim bed and in the dining of respond to questio 0 p.m., registered nu- view the behavior mo- ly flow records. After e was asked what s the resident exhibit one." ad a diagnosis of anx ssment dated 10/25/ sident's cognitive ski ing were intact. The nented he had receiv tion 7 of the 7 days p reviewed 10/25/15 sident had an alterat The s/s of behaviors is l yelling out at staff a	ored were eking. hted the dal (an for es during room. ns asked rse (RN) onitoring/ review of red. She dety 15 Ils for red an prior to the ion in to be nd		·			
L	1					······································	<u></u>	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL DPLAN OF CORRECTION IDENTIFICATION NUMBER				PLE CONSTRUCTION	(X3) DATE SL COMPLE	
	375275			B. WING		02/04	4/2016
	ROVIDER OR SUPPLIER	ENTER	6501 N	ORTH MAG	STATE, ZIP CODE CARTHUR /, OK 73132	-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCI T BE PRECEDED BY FULL INTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 329	dated 01/2016, doc be monitored for an The current physici resident was to be antianxiety medical The resident was or rested in bed. She her needs known. On 02/03/16 at 1:00 review the behavior record. After review asked if the specific exhibited for anxiet "No." 4. Resident #9 had major depressive of and convulsions. Nurses' notes for 1 documentation of b for an antipsychotic The behavior moni contain documenta the need for an ant A physician's order the resident was to antipsychotic medic diagnosis for the ad documented the re decision making sh	an's orders documented the resider administered Ativan tion) 3 times a day. bserved multiple tim was alert and able to 0 p.m., RN #1 was a r/intervention monito wing the documents, c s/s of behavior the y was monitored. Sh d diagnoses that inclu- lisorder, dementia, a 1/2015 did not contab behaviors to indicate	nted the (an es as she o make sked to ring flow she was resident ne stated, uded norexia, in the need 015 did not ndicate n. umented n vo quel was	F 329			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIEI IDENTIFICATION NUM		1 1	PLE CONSTRUCTION G	(X3) DATE SU COMPLE	
		375275		B. WING		02/04	4/2016
1	ROVIDER OR SUPPLIER				STATE, ZIP CODE	- 4	
WARR A	CRES NURSING CI	ENTER			CARTHUR 7, OK 73132		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE F BE PRECEDED BY FULL F ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 329	Continued From pa antipsychotic medic assessment. The a a diagnosis for the antipsychotic. The care plan upda resident received a staff were to observe specific behaviors for medication, and rea reduction. A monthly physician documented the re- for convulsions. On 02/03/16 at 10: the documentation administration of S- antipsychotic was to convulsions. He st asked if the reason medication was doo not. 5. Resident #5 had anxiety disorder, de	·	locument ented the ation. The entify the of the of the 16 e Seroquel as shown r the ced if the r le was n of the d it was	F 329			
	thrive. A physician's order dated 11/18/15 documented a urinalysis (UA) with culture and sensitivity (C&S) was to be completed.						
		ed 11/25/15 documen tained for an antibioti					
	resident was incon	ated 11/25/15 docum tinent and at risk for i ule out UTI with chan	infections.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM				(X3) DATE S COMPLI	
		375275 B. WING 02/04/2016		4/2016			
	ROVIDER OR SUPPLIER	ENTER	6501 N	ORTH MAC	TATE, ZIP CODE CARTHUR 7, OK 73132		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ATEMENT OF DEFICIENCI T BE PRECEDED BY FULL ENTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 329 F 329 SS=D	continence and pro The staff were to n in the resident's uri documented a UA 11/18/15 and an ar on 11/25/15. There was no docu prior to 11/25/15 to experiencing s/s of documentation to in requested or order. The quarterly asse documented the re in cognition. The a resident was freque bowel/bladder and toileting. On 02/02/16 at 10: the nurses' notes a asked for documer UA was collected a administered for a notes and stated the indicate the need for antibiotic. 483.75(j)(1) ADMIN The facility must priservices to meet the facility is responsib of the services. This Requirement Based on observation interview, it was determined for a notes and stated the facility is responsible.	omote adequate hydr otify the physician of ne. The care plan with C&S was orderen tibiotic was started for umentation in the nur indicate the resident f a UTI. There was n ndicate the reason the ed. ssment dated 12/07/ sident was severely assessment documer ently incontinent of was dependent on s 20 a.m., the DON was and physician's orders nation to indicate the and an antibiotic was UTI. He reviewed the here was no documer or the laboratory test	changes ed on or a UTI ses' notes was o le UA was 15 impaired nted the taff for as shown s. He was reason a e nurses' ntation to or the atory nts. The timeliness ced by: nd failed to	F 329	·		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		375275		B, WING		02/04/2016	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CI WARR ACRES NURSING CENTER 6501 NORTH OKLAHOMA (CONTRACTOR) OKLAHOMA (CONTRACTOR)					CARTHUR		
(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 CORRECT (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	N SHOULD BE COM	
F 502			F 502	Resident #2 laboratory nee reviewed by the Physician updated as needed. Residents residing in the fa have the ability to be affect this alleged practice. Staff in-service was done 3 by the DON/Designee on la process and follow up. Audit of Lab orders was do D.O.N. and/or Designee w random audits of assessm 1-2 times a week to monito process for 4 weeks with re forwarded to the QAPI con for review. Then monthly to months with results forward the QAPI committee for review	ory needs were vsician and n the facility e affected by done 3/5/2016 ee on laboratory up. was done. mee will do sessments monitor this with results PI committee onthly times 3 forwarded to		

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