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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375275	A. BUILDING ______ B. WING ______	02/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARR ACRES NURSING CENTER	6501 NORTH MACARTHUR OKLAHOMA CITY, OK 73132

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 02/01/16 to 02/04/16 a recertification/relicensure survey was conducted.	F 000		
F 278 SS=D	483.20(g) - (j) ASSESSMENT 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 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. This Requirement is not met as evidenced by: 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	F 278	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 or conclusion set forth-in in the statement of Deficiencies. 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. Residents residing in the facility has the ability to be affected by this alleged practice. Staff In-service was done on 03/05/2016 by the DON and designee for the accuracy of assessments and process. Continue on next page	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Deana McMillen	Administrator	2-26-16

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 278	Continued From page 1 assessments were reviewed for accuracy. The inaccuracy was in regard to the brief interview for mental status (BIMS). The facility census was 89. Findings: Resident #4 had diagnoses to include dementia. The quarterly assessment dated 12/21/15 documented the resident usually made herself understood and usually understood others. The assessment asked the question, "Should [BIMS] 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. The resident was observed lying in her bed and seated in her wheelchair. She was able to answer simple questions appropriately. 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 278	D.O.N. and/or Designee will do random audits of assessments 1-2 times a week to monitor this process for 4 weeks with results forwarded to the QAPI committee for review. Then monthly times 3 months with results forwarded to the QAPI committee for review.	3-14-16
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care	F 279	Residents # 2, 5 and 6 care plan were reviewed and updated as needed. Resident residing in the facility with behaviors exhibited for the administration of anti-psychotic	

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F 279	Continued From page 2 plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This Requirement is not met as evidenced by: Based on observation, record review, and interview, it was determined the facility failed to ensure care plans were fully developed for 3 (#2, 5, and #6) of 15 sampled residents whose care plans were reviewed for completeness. The areas not fully developed were in regards to behaviors exhibited for the administration of antipsychotic and antianxiety medications. The facility census was 89. Findings: 1. Resident #2 had diagnoses to include dementia, major depressive disorder, delusional disorder, and brief psychotic disorder. The quarterly assessment dated 11/26/15 documented the resident's cognitive skills were severely impaired. The assessment documented he had received an antipsychotic medication 7 of the 7 days prior to the assessment. The behavior/intervention monthly flow records dated 12/2015, 01/2016, and 02/2016	F 279	and anti anxiety drugs have the ability to be effected by this alleged practice. Residents receiving anti-psychotic and anti-anxiety drugs care-plans were reviewed and updated as needed. D.O.N. and/or Designee will do random audits of assessments 1-2 times a week to monitor this process for 4 weeks with results forwarded to the QAPI committee for review. Then monthly times 3 months with results forwarded to the QAPI committee for review.	3-14-16

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F 279	Continued From page 3 documented the target behaviors to be monitored included cussing to staff and others and exit seeking. The care plan last reviewed 12/02/15 documented staff were to observe for side effects of the antipsychotic medication. There was no documentation of the behaviors exhibited by the resident for the administration of Risperdal. The current physician's orders documented the resident was to be administered Risperdal (an antipsychotic medication) 2 times a day. On 02/02/16 the resident was observed lying in bed and again in the dining room. He was pleasant. He was appropriately dressed for the weather. He was able to make his needs known. At 2:10 p.m., registered nurse (RN) #1 was asked to review the care plan. She was asked if specific behaviors were identified for the administration of Risperdal. After reviewing the care plan, she stated, "No." 2. Resident #5 had diagnoses that included anxiety disorder and dementia. A physician's order dated 09/25/15 documented the administration of Ativan (an anti-anxiety/psychotropic medication) every 6 hours as needed for agitation and anxiety. The quarterly assessment dated 12/07/15 documented the resident was severely impaired in cognition. The assessment documented the resident had not experienced behaviors in the 7 days prior to the assessment. The care plan updated 12/15/15 documented the	F 279		

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F 279	Continued From page 4 resident was at risk for complications related to medications used for anxiety. The staff were to identify specific behaviors to warrant as needed dosing of psychotropic medications. The staff were to attempt to identify environmental or basic needs as the cause for changes in mood and behaviors prior to medicating as appropriate. The care plan did not identify the specific behaviors to warrant the administration of an anti-anxiety. On 02/03/16 at 10:00 a.m., the director of nurses was shown the care plan and asked if the behaviors for the administration of an anti-anxiety were identified on the care plan. He reviewed the care plan and stated they were not identified on the care plan. 3. Resident #6 had diagnoses to include delirium due to a known physiological condition, anxiety disorder, major depressive disorder, and dementia. The quarterly assessment dated 12/02/15 documented the resident was cognitively intact. The assessment documented the resident had experienced no signs/symptoms of delirium, and no hallucinations or delusions in the 7 days prior to the assessment. The assessment documented she had been administered an antipsychotic medication 7 of the 7 days prior to the assessment. The care plan dated 12/08/15 documented the resident was at risk for complications related to psychotropic medication which included Abilify (an antipsychotic medication). The care plan documented the specific behaviors were to be identified which warranted as needed dosing.	F 279		

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F 279	Continued From page 5 There was no documentation to indicate specific behaviors for which Abilify was ordered/administered. Current physician's orders documented the resident was to be administered Abilify at bedtime for dementia. 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 279		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	Residents # 2,5 6,9 and #10 were reviewed and updated as needed for their "unnecessary medications". Residents residing in the facility has the potential to be effected by this alleged practice In-service was done on medication use and need with the need of diagnosis and/or sign/symptom for avoidance of medication that could unnecessary. D.O.N. and/or Designee will do random audits of assessments 1-2 times a week to monitor this process for 4 weeks with results forwarded to the QAPI committee for review. Then monthly times 3 months with results forwarded to the QAPI committee for review.	3-14-16

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F 329	Continued From page 6	F 329		

This Requirement is not met as evidenced by:
Based on observation, record review, and interview, it was determined the facility failed to ensure unnecessary medications for 5 (#2, 5, 6, 9, and #10) of 15 sampled residents whose clinical records were reviewed for unnecessary medication. The unnecessary medications were in regard to a urinary tract infection (UTI), diagnoses and monitoring of behaviors related to antianxiety and antipsychotic medication. The facility census was 89. Findings:

1. Resident #6 had diagnoses to include delirium due to a known physiological condition, anxiety disorder, major depressive disorder, and dementia.

The quarterly assessment dated 12/02/15 documented the resident was cognitively intact. The assessment documented the resident had experienced no signs/symptoms (s/s) of delirium, and no hallucinations or delusions in the 7 days prior to the assessment. The assessment documented she had been administered an antipsychotic medication 7 of the 7 days prior to the assessment.

The care plan dated 12/08/15 documented the resident was at risk for complications related to psychotropic medication which included Abilify (an antipsychotic medication). The care plan documented the specific behaviors were to be identified which warranted as needed dosing.

There was no documentation to indicate specific behaviors for which Abilify was ordered/administered.

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F 329	Continued From page 7 Current physician's orders documented the resident was to be administered Abilify at bedtime for dementia. The behavior/intervention flow record dated 12/2015 documented the resident was monitored for yelling and insomnia. The behavior/intervention flow record dated 01/2016 did not identify behaviors to be monitored. The flow record documented "[side/effects] only " and did not identify Abilify as a medication monitored. On 02/02/16 at 11:00 a.m., the director of nurses (DON) was asked if dementia was an appropriate diagnosis for the administration of Abilify. He stated, "No." He was shown the behavior flow record and asked if yelling was a behavior for which an antipsychotic (Abilify) medication should be administered. He stated, "No." He was asked if a behavior flow record for the monitoring of Abilify had been completed for 01/2016. He stated he could not find one. 2. Resident #2 had diagnoses to include delusional disorder, and brief psychotic disorder. The quarterly assessment dated 11/26/15 documented the resident's cognitive skills for daily decision making were severely impaired. The assessment documented he had received an antipsychotic medication 7 of the 7 days prior to the assessment. The care plan last reviewed on 12/2/15 documented the staff were to monitor for the side effects of antipsychotic medications. There was no documentation to indicate the signs/symptoms (s/s) of behavior the resident exhibited.	F 329		

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F 329	Continued From page 8	F 329		

The behavior/intervention monthly flow records dated 12/2015, 01/2016, and 02/2016 documented the behaviors to be monitored were cussing to staff and others, and exit seeking.

The current physician's orders documented the resident was to be administered Risperdal (an antipsychotic medication) 2 times a day for delusions.

The resident was observed multiple times during the survey lying in bed and in the dining room. The resident did not respond to questions asked by the surveyor.

On 02/02/16 at 2:10 p.m., registered nurse (RN) #1 was asked to review the behavior monitoring/ intervention monthly flow records. After review of the documents, she was asked what behaviors/delusions the resident exhibited. She stated, "There is none."

3. Resident #10 had a diagnosis of anxiety disorder.

The quarterly assessment dated 10/25/15 documented the resident's cognitive skills for daily decision making were intact. The assessment documented he had received an antianxiety medication 7 of the 7 days prior to the assessment.

The care plan last reviewed 10/25/15 documented the resident had an alteration in mood/behaviors. The s/s of behaviors to be monitored included yelling out at staff and verbally abusive to staff.

The behavior/intervention monthly flow record

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F 329	Continued From page 9 dated 01/2016, documented the resident was to be monitored for anxiety. The current physician's orders documented the resident was to be administered Ativan (an antianxiety medication) 3 times a day. The resident was observed multiple times as she rested in bed. She was alert and able to make her needs known. On 02/03/16 at 1:00 p.m., RN #1 was asked to review the behavior/intervention monitoring flow record. After reviewing the documents, she was asked if the specific s/s of behavior the resident exhibited for anxiety was monitored. She stated, "No." 4. Resident #9 had diagnoses that included major depressive disorder, dementia, anorexia, and convulsions. Nurses' notes for 11/2015 did not contain documentation of behaviors to indicate the need for an antipsychotic medication. The behavior monitoring sheet for 11/2015 did not contain documentation of behaviors to indicate the need for an antipsychotic medication. A physician's order dated 12/06/15 documented the resident was to receive Seroquel (an antipsychotic medication) at bedtime. No diagnosis for the administration of Seroquel was documented. The annual assessment dated 12/13/15 documented the resident was independent in decision making skills. The assessment documented the resident had received an	F 329		

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F 329	Continued From page 10	F 329		

antipsychotic medication in the 7 days prior to the assessment. The assessment did not document a diagnosis for the administration of the antipsychotic.

The care plan updated 12/2015 documented the resident received a psychotropic medication. The staff were to observe for side effects, identify the specific behaviors for the administration of the medication, and request a gradual dose reduction.

A monthly physician's order dated 01/2016 documented the resident was to receive Seroquel for convulsions.

On 02/03/16 at 10:05 a.m., the DON was shown the documentation and the diagnosis for the administration of Seroquel. He was asked if the antipsychotic was to be administered for convulsions. He stated probably not. He was asked if the reason for the administration of the medication was documented. He stated it was not.

5. Resident #5 had diagnoses that included anxiety disorder, dementia, and adult failure to thrive.

A physician's order dated 11/18/15 documented a urinalysis (UA) with culture and sensitivity (C&S) was to be completed.

A nurse's note dated 11/25/15 documented an order had been obtained for an antibiotic to treat a UTI.

The care plan updated 11/25/15 documented the resident was incontinent and at risk for infections. The staff were to rule out UTI with changes in

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F 329	Continued From page 11 continence and promote adequate hydration. The staff were to notify the physician of changes in the resident's urine. The care plan documented a UA with C&S was ordered on 11/18/15 and an antibiotic was started for a UTI on 11/25/15. There was no documentation in the nurses' notes prior to 11/25/15 to indicate the resident was experiencing s/s of a UTI. There was no documentation to indicate the reason the UA was requested or ordered. The quarterly assessment dated 12/07/15 documented the resident was severely impaired in cognition. The assessment documented the resident was frequently incontinent of bowel/bladder and was dependent on staff for toileting. On 02/02/16 at 10:20 a.m., the DON was shown the nurses' notes and physician's orders. He was asked for documentation to indicate the reason a UA was collected and an antibiotic was administered for a UTI. He reviewed the nurses' notes and stated there was no documentation to indicate the need for the laboratory test or the antibiotic.	F 329		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This Requirement is not met as evidenced by: Based on observation, record review, and interview, it was determined the facility failed to ensure a physician ordered laboratory test was	F 502		

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F 502	Continued From page 12 obtained for 1 (#2) of 4 sampled residents whose medical records were reviewed for laboratory services. The facility census was 89. Findings: Resident #2 had diagnoses to include dementia, diabetes mellitus, delusional disorder, hypertension, and brief psychotic disorder. The quarterly assessment dated 11/26/15 documented the resident's cognitive skills for daily decision making were severely impaired. The assessment documented the resident required assistance with activities of daily living. The care plan dated 11/26/15 did not address laboratory tests. The current physician's orders documented the resident was to have a basic metabolic panel (BMP) drawn every 6 months in September and March. There was no documentation to indicate a BMP had been completed for 09/2015. The resident was observed multiple times during the survey lying in bed and in the dining room. The resident did not respond to questions from the surveyor. On 02/02/16 at 2:00 p.m., registered nurse #1 was asked to review the physician's orders for laboratory services. She was asked how often the BMP was to be drawn. After review of the physician's orders, she stated, "Every 6 months." She was asked when the last BMP was drawn. She stated in March. She was asked if the physician's orders had been followed. She stated, "No."	F 502	Resident #2 laboratory needs were reviewed by the Physician and updated as needed. Residents residing in the facility have the ability to be affected by this alleged practice. Staff in-service was done 3/5/2016 by the DON/Designee on laboratory process and follow up. Audit of Lab orders was done. D.O.N. and/or Designee will do random audits of assessments 1-2 times a week to monitor this process for 4 weeks with results forwarded to the QAPI committee for review. Then monthly times 3 months with results forwarded to the QAPI committee for review.	3-14-16