STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006738	A. BUILDING: _____ B. WING _____	12/10/2021

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S 000	Initial Comments Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations #1: 300.1010h) 300.1210d)5) 300.1220b)2) Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's	S9999	**Attachment A** **Statement of Licensure Violations**	

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clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.

These Requirements are not met as evidenced by:

Based on observation, interview and record review, the facility failed to identify 4 unstageable pressure injuries to a resident with current pressure injuries, failed to assess and document the pressure injuries and failed to implement interventions to prevent worsening of the pressure injuries.

This applies to 1 of 1 resident (R100) reviewed for pressure injuries in the sample of 3.

The findings include:

R100's Admission Record, printed by the facility on 12/8/21, showed she was admitted to the facility on 12/11/2000 with diagnoses including

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S9999	Continued From page 2 Dementia, Osteoarthritis and age-related Osteoporosis. On 12/7/21 at 10:33 AM, V23 (Hospice Nurse) was in R100's room assessing R100. R100 had a pressure injury to her left buttock, left medial foot, right lateral foot, right medial foot, her right great toe and the top of her right second toe. After the assessment was completed, V23 and V22 (Certified Nursing Assistant-CNA) repositioned R100 and covered her up. Both of R100's feet were resting directly on her bed with no offloading of pressure areas to bilateral feet. R100's Skin/Wound Assessment dated 11/20/21 showed she had a pressure injury to her left buttocks/sacrum area and another on her left medial foot. R100's Skin/Wound Assessment dated 11/25/21 only documented a pressure injury to her left buttock. No wound assessments documented from 11/26/21 through 12/7/21. On 12/7/21 at 2:03 PM, V2 (Director of Nursing-DON) stated there were no additional skin/wound assessments after the assessment of 11/25/21 in R100's electronic medical record, and that is all the facility had. V2 and this surveyor went to R100's room to do a skin check. The wound to R100's right medial foot was visible when the covers were drawn back. V2 stated it looked "like an old blister or something". Both of R100's feet were still resting directly on the mattress, with no offloading of the pressure areas. On 12/8/21 a Skin/Wound Assessment was provided showing an assessment of R100's wounds was performed on 12/8/21 at 2:43 AM. The assessment showed R100 had a stage II pressure injury to her left buttocks measuring 1.0	S9999		

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S9999	Continued From page 3 centimeter (cm) x 0.6 cm x 0.2 cm; a pressure injury to her left medial foot measuring 0.5 x 0.6 cm with 95% eschar (non-viable, black tissue); an unstageable pressure injury to her right lateral foot measuring 1.6 cm x 1.7 cm with 100% eschar tissue; an unstageable pressure injury to her right medial foot measuring 0.7 cm x 0.9 cm with 100% eschar tissue; and an unstageable pressure injury to her right great toe measuring 0.1 cm x 0.7 cm with 100% eschar tissue. R100's Mobility care plan initiated on 9/24/19 showed R100 had limited physical mobility related to weakness and contractures. R100's Impaired Skin Integrity care plan initiated on 5/20/21 showed interventions in place were "Monitor my skin routinely with showers/baths. Report any new issues to the nurse...Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. R100's December 2021 Treatment Administration Record (TAR) showed "Offload heals, ankles and feet at all times." With a start date of 12/8/21. The TAR showed no treatment in place for the pressure injuries to R100's right foot, right great toe and right second toe. R100's Medication Treatment Record, printed by the facility on 12/8/21 showed no treatment orders in place for the medial and lateral pressure injuries on R100's right foot, or her right great toe and second toe. On 12/9/21 at 9:13 AM, V17 (Registered Nurse-RN) stated for a resident who is not able to reposition themselves skin checks should be done every shift by the nurse and with all daily	S9999		

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cares by the CNAs. V17 stated R100 has daily and nightly skin checks because she is more prone to skin breakdown. V17 stated it is important to make sure that the skin checks are done, and any concerns are reported to her doctor and hospice. V17 stated the wound nurse (V20) should also be informed so she can keep track of the wounds and suggest any new treatment options.

On 12/9/21 at 9:38 AM, V18 (RN) said for a resident who is unable to reposition themselves it is important for staff to monitor for any skin concerns. If any concerns are identified, the resident should be placed on the 72-hour monitoring list. V18 stated for R100 the doctor and hospice should be notified as well as the POA (power of attorney) and wound nurse. V18 stated an assessment should be done on an area when it is identified. V18 stated any new areas of concern are listed on the resident's TAR with any interventions started. V18 stated a resident who is unable to reposition themselves is more prone to skin breakdown. V18 stated it is important to make sure an assessment is done, and the doctor is notified to get new orders, so the resident's wound does not get worse. If left untreated, it could possibly develop infections. It is also important to do assessments to see if the wound is getting better or worse.

On 12/9/21 at 10:00 AM, V19 (RN) stated skin checks should be done every two hours with care and repositioning for a resident who is unable to reposition themselves. They are more prone to skin breakdown or pressure. Any new skin concerns should be assessed and reported to the doctor, so the doctor is aware and any new orders that are needed are obtained. V19 stated, the assessment should be documented in the

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resident's electronic medical record. V19 stated it is important to assess and document the assessment to make sure the wound is not getting worse and the treatments in place are working.

On 12/9/21 at 1:09 PM, V20 (Wound Nurse) stated she was not aware of any new areas of pressure for R100 until V2 left her an email asking her to do a full body assessment on R100. V20 stated she spoke with one of the night nurses and the nurse said she saw the new areas either Sunday or Monday (12/5/21 or 12/6/21) on the overnight shift. V20 stated she was not notified of the new areas and she did not see any assessments done on the new areas of pressure to R100's right lateral, medial foot and toes. V20 stated the shower aides and CNAs are the facility's first line of defense in preventing and identifying skin concerns. V20 stated things that staff would see prior to eschar tissue would be the skin not blanching, redness, a blister, mushy skin, discolored/purplish skin. V20 stated it is important for the CNAs to report to the nursing staff whenever they see any areas of concerns so the wound can be assessed and documented, the doctor and family can be updated and a new treatment can be started to prevent infection, prevent further breakdown or injuries, and to maintain the resident's quality of life.

On 12/9/21 at 2:24 PM, V4 (Nurse Practitioner-NP) stated she would expect staff to be vigilant in monitoring for skin issues with a resident that is not able to reposition themselves. V4 stated she would expect staff to identify an area of pressure prior to it becoming unstageable with eschar. V4 stated after an area of concern is identified, she would expect staff to assess the area and notify the doctor or NP for new orders

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S9999	Continued From page 6 and to document the wound in the resident's electronic medical record. On 12/9/21 at 2:58 PM, V21 (former Medical Advisor for the facility) stated she would expect increased monitoring done on a resident that the facility staff have to do everything for, adding It is important to evaluate, assessing and documenting new skin issues is part of nursing. V21 stated it is important to prevent further breakdown and infection and for the resident's comfort. V21 said she would expect the staff to identify an area of pressure prior to it becoming 100% eschar. The facility's Skin Care Policy, with a review date of 7/2010, showed "3. Those residents identified as moderate or high risk for decubitus will be candidates for additional nutritional support and treatment per Routine Treatment Protocol. 4. Those residents with an actual decubitus will be monitored closely, and more aggressive care will include BID/TID (2/3 times daily) treatment schedules (depending on the resident's need), weekly assessment of healing progress, and changes in the treatment as required by the states of healing. 5. Reddened areas, broken or excoriated skin or other evidence of skin breakdown due to pressure observed by CNAs will be reported to the nurse on duty who will assess the appropriate treatment. 6. Continued monitoring of the resident's skin condition will be accomplished by staff's observations of skin condition during daily care." The undated facility document titled Skin Care Interventions showed common skin care interventions for pressure include offloading weight.	S9999		

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S9999	Continued From page 7 The undated facility document titled Skin Documentation showed documentation should include the type of wound, the staging or classification, the correct anatomical position, the wound measurements, a description of the wound base, if the wound has any signs or symptoms of infection, any drainage or odor, if the wound has any undermining or tunneling, what the skin around the wound looks like, if the resident is having any pain at wound site, what the treatment is and the resident's response to treatment. The document showed any questions or concerns regarding skin care can be addressed with the wound care nurse, if urgent address with the supervisor on duty. The document also showed staff can send concerns via email and to please send to all nursing supervisors as well as the wound nurse. The facility document titled Prevention Protocol/Skin Care Program, with a reviewed date of 7/2010, showed if a resident is a high risk for skin concerns/pressure interventions in place are "Alternating air pressure overlay on bed/pressure relieving pad in wheelchair with agreement. Elbow/heel protectors, bed cradle as needed, and turning schedule. (B) Statement of Licensure Violations #2: 300.1010h) 300.1210d)6) 300.1220b)6) Section 300.1010 Medical Care Policies h) The facility shall notify the resident's	S9999		

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S9999	Continued From page 8 physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 6) Developing and maintaining nursing service objectives, standards of nursing practice, written policies and procedures, and written job descriptions for each level of nursing personnel. These Requirements are not met as evidenced by:	S9999		

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Based on observation, interview and record review, the facility failed to call the doctor to report a resident on anticoagulant therapy after an unwitnessed fall, failed to initiate neurological checks on the resident after the fall and the facility failed to ensure treatment cabinets containing medications remained locked when not in use. This applies 17 residents (R101, R119, R110, R118, R117, R102, R107, R108, R103, R104, R105, R106, R109, R111, R114, R115, R116) reviewed for safety and supervision outside the sample.

The findings include:

I. R101's Admission Record printed by the facility on 12/8/21 showed she had diagnoses including Bipolar Disorder, Dysphasia (difficulty speaking), Stroke, Syncope (fainting or sudden temporary loss of consciousness) and collapse.

On 12/7/21 at 2:20 PM, R101 was in her room, sitting in her recliner. R101 had a call alarm necklace around her neck. R101 stated she has had falls in the facility.

R101's Resident Occurrence Analysis forms show R101 had unwitnessed falls on 9/14/21, 10/15/21 and 11/4/21. The document dated 10/15/21 showed R101 was not able to explain the reason the occurrence happened or what she was trying to do when the incident occurred. The document showed R101 was found on the floor, however she denied falling. R101's progress note dated 9/14/21 showed R101 had a fall at 5:05 PM and the doctor was notified via fax at 5:44 PM. Progress notes show no further monitoring was completed until 9/15/21 at 5:42 AM.

R101's progress note dated 10/15/21 showed she

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was found crawling on the floor in front of the window and had her wheelchair on top of her. Resident denied falling. No injury noted. R101's doctor was faxed regarding incident at 11:39 AM. On 10/15/21 at 5:28 PM, R101's doctor noted that he received the fax. The notes show no assessment was completed after the initial assessment until 10/15/21 at 10:43 PM.

R101's progress note dated 11/4/21 at 1:42 PM, showed she had another fall and was found on the floor in her room on her knees. The note shows R101's recliner was tipped over. The note showed R101 denied hitting her head. R101's doctor was faxed regarding the fall. R101's Resident Occurrence Analysis form dated 11/4/21 showed the fall was unwitnessed. The notes show R101's doctor responded to the fax on 11/4/21 at 9:55 PM. The notes show the next assessment was completed on 11/4/21 at 9:55 PM. Another assessment was not completed until 11/5/21 at 6:14 AM.

R101's Medication Administration Records from September 2021 through December 2021 showed R101 received an anticoagulant (blood thinner medication) on a regular basis (varies based on lab results) during that time period.

On 12/9/21 at 10:52 AM, V2 (Director of Nursing-DON) stated there are no neuro (neurological) checks in R101's electronic charting between 9/1/21 and the present. V2 stated during a neuro check assessment, the nurse checks the resident's vital signs, orientation, level of alertness, the resident's pupils to make sure they are equal and react to light and accommodation. V2 stated the nurse checks to make sure the resident responds to simple commands and checks the residents' pain as well

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as the hands and legs for grip and strength and resident's range of motion. The nurse also checks for nausea and vomiting. V2 stated neuro checks are initiated if the resident has signs of hitting their head, the resident states that they hit their head, or if it is suspected that they hit their head. V2 stated for an unwitnessed fall for a resident on anticoagulants, it depends on the resident's level of consciousness if neuro checks are performed. V2 stated if a resident hit their head and had a brain bleed, they may not be able to appropriately state if they hit their head or not, however, they would also have other things going on too-cognitively and may not respond to questions appropriately. V2 stated R101 has short-term memory problems. V2 stated the physician would be notified if a resident hit their head and was on an anticoagulant medication. V2 stated 9 times out of 10 the doctor says to send the resident to the ER (emergency room). At 11:26 AM, V2 stated she thinks R101 was denying the fall on 10/15/21 out of embarrassment. V2 stated R101 may deny hitting her head out of embarrassment as well. V2 stated she did not know if you can rely on what R101 tells you about what happened the day before, but she thinks she does have the ability to recall what happened within a certain time period. V2 stated with R101 having an unwitnessed fall, being on anticoagulant therapy, and having some cognitive issues, it would be better out of precaution to do neuro checks. V2 added, "It is better to do the assessment and not need it, than to not do the assessment and have needed it."

On 12/9/21 at 9:13 AM, V17 (Registered Nurse-RN) stated if a resident has an unwitnessed fall, the nurse does not automatically start doing neuro checks. V17 stated if a resident hit their head and is injured, they may not be able

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to say if they hit their head or not. If on an anticoagulant, the resident would be more susceptible to bleeding. If on an anticoagulant and had an unwitnessed fall, the resident could have hit their head and developed a brain bleeding.

On 12/9/21 at 9:38 AM, V18 (RN) stated she was the nurse working on 10/15/21 when R101 had an unwitnessed fall. V18 stated neuro checks are located in the assessment tab in the resident's electronic medical record. V18 stated if there are not any neuro checks in the assessment tab, then there probably was not any done. V18 stated the resident's doctor should be called for a resident with an unwitnessed fall who is on an anticoagulant because they are more susceptible to bleeding. V18 stated if a resident had a fall and hit their head, they may not be able to tell you they hit their head. V18 stated R101 has a hard time communicating. She is unable to translate what she is trying to say. V18 stated R101 has short-term memory problems. V18 said occasionally R101 will ask us to do things for her that we have already done.

On 12/9/21 at 10:00 AM, V19 (RN) stated she was the nurse working on 11/4/21 when R101 had an unwitnessed fall. V19 stated R101 was on her knees on the floor and her recliner was tipped over. V19 stated for a resident on an anticoagulant with an unwitnessed fall, the doctor should probably be called instead of faxed because they are more susceptible to bleeding. V19 stated the resident could develop a brain bleed. V19 stated if the resident had a brain bleed, it could affect their ability to answer appropriately if they hit their head or not. V19 stated for R101's unwitnessed fall on 10/15/21, she faxed the doctor and did not call the doctor.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK CREST	2944 GREENWOOD ACRES DRIVE DEKALB, IL 60115

(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) COMPLETE DATE
S9999	Continued From page 13 V19 stated she should have called the doctor. V19 was able to identify what was involved in a neuro check assessment and said she did not do a full neuro check assessment on R101 on 10/15/21 after her unwitnessed fall. On 12/9/21 at 2:24 PM, V4 (Nurse Practitioner) stated she would have a hint of suspicion that a resident with short-term memory problems report that they did not hit their head may not be accurate. V4 stated she would expect neuro checks to be started and the resident to be closely monitored if they were on anticoagulants, had an unwitnessed fall and had memory problems. On 12/9/21 V21 (former Medical Advisor for the facility) stated she would not rely on a resident with any kind of cognitive issues to tell me if they hit their head or not for an unwitnessed fall. V21 stated she would likely send the resident out to the emergency room if there was an unwitnessed fall, and the resident was on anticoagulant therapy. V21 stated, "You just can't take the resident's report on not hitting their heads with any cognitive problems." V21 stated I would expect them to call, not fax. V21 added, she always prefers a call over a fax, adding "A fax would delay the treatment." R101's cognition care plan initiated 2/27/2020 showed she has impaired cognitive function due to short-term memory loss. R101's activities of daily living (ADLs) care plan showed she has an ADL self-care deficit related to confusion and impaired balance. The facility's 4/08 policy and procedure titled Resident Falls Policy and Procedure showed Response to falls...If a resident is suspected to	S9999		

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S9999	Continued From page 14 have hit their head, the licensed nurse on duty will complete a neurological assessment every 4 hours for the first 24 hours post incident. Any changes in neurological status should be relayed to the physician immediately. The physician should be notified of all falls. If a resident is taking blood thinners and hits their head, the physician should be notified via phone immediately. (B) Statement of Licensure Violations #3: 300.1220b)6) 300.1640a) 300.1650a) Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 6) Developing and maintaining nursing service objectives, standards of nursing practice, written policies and procedures, and written job descriptions for each level of nursing personnel. Section 300.1640 Labeling and Storage of Medications a) All medications for all residents shall be properly labeled and stored at, or near, the nurses' station, in a locked cabinet, a locked medication room, or one or more locked mobile medication carts of satisfactory design for such storage. Section 300.1650 Control of Medications	S9999		

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S9999	Continued From page 15 a) The facility shall comply with all federal and State laws and State regulations relating to the procurement, storage, dispensing, administration, and disposal of medications. These Requirements are not met as evidenced by: II. The facility failed to ensure treatment cabinets containing medications remained locked when not in use. This applies to R119, R110, R118, R117, R102-R11, and R14-R16. On 12/8/21 at 9:46 AM, R119 was in a chair in her room. V11 Registered Nurse (RN) opened an unlocked cabinet in R119's room to obtain a medicated patch. Inside the cabinet was a sharps container, blood glucose supplies, and emergency glucose. At 9:48 AM, V11 stated the cabinet should be locked. At 2:45 PM, V11 confirmed the contents of the cabinet and that the cabinet was not secured during the medication pass this morning. R119's physician order sheet does not show a diagnosis of Diabetes, and order for blood glucose monitoring, or emergency glucose. On 12/08/21 at 10:28 AM - 10:44 AM, resident rooms with doors open or ajar were observed on Health Care West (HCW) for locked doors on treatment cabinets. R110 was in his room in a chair. The doors on the treatment cabinet in R110's room were unlocked. There was a prescription multi dose inhaler in the cabinet. R110 was observed earlier ambulating with a walker and unsupervised.	S9999		

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S9999	Continued From page 16 On 12/9/21 at 9:16 AM, V2 Director of Nursing and V3 Assistant Director of Nursing stated R110 had a recent status change with increased confusion and weakness. We are currently waiting on urinalysis culture and sensitivity results. R110 is extremely hard of hearing also. R110's physician order sheet showed a current order for the prescription inhaler. R118 was in her bed in her room. R118's treatment cabinet in her room was unlocked. There were a bottle of prescription eye drops and a baggie with medicated pain patches in the cabinet. R118's physician order sheet showed a current order for the prescription eye drops and medicated patch. R118's order sheet showed diagnoses including Alzheimer's Disease, Glaucoma, Dementia with behavioral disturbance and brief Psychotic Disorder. R117 was in her room in a chair. R'117's treatment cabinet in her room was unlocked. There was an open (top tore off the box) box of lancets (used to puncture skin to check blood glucose level) and a spray bottle of wound cleanser in the cabinet. R117's physician orders do not show a diagnosis of Diabetes or an order for blood glucose monitoring. These orders do not have any indications for the use of wound cleanser. This order sheet showed a diagnosis of Alzheimer's Disease. The 12/7/21 facility provided census list showed R102-111 and R14-16 (13 residents) who resided on Health Care West (HCW) were not	S9999		

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interviewable and mobile in a wheelchair or walking by themselves. All of the unlocked treatment cabinets were located on HCW.

On 12/8/21 at 11:11 AM V3 Assistant Director of Nursing (ADON) stated residents on the list not highlighted in yellow are not interviewable.

V2 Director of Nursing (DON) highlighted the census list of Health Care West (HCW) residents to indicate in green highlighter residents who were mobile in a wheelchair or self-ambulatory.

On 12/9/21 at 9:16 AM, V2 Director of Nursing stated most of our confused residents can still tell you they're at this facility because they've been here for decades.

R102's face sheet showed a diagnosis of Dementia.

R103's face sheet showed diagnosis of Dementia and cognitive social or emotional deficit following a non-traumatic brain bleed.

R104's face sheet showed diagnoses of Alzheimer's Disease, Vascular Dementia, unspecified Dementia with behavioral disturbance, and Anxiety Disorder.

R105's face sheet showed diagnoses of Dementia with behavioral disturbance and Anxiety Disorder.

R106's face sheet showed diagnoses of Alzheimer's Disease and Macular Degeneration.

R107's face sheet showed diagnoses of Alzheimer's Disease, Anxiety disorder, and Cerebral Infarction.

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R108's 12/2/21 facility assessment showed R108 was only oriented to person.

R109's face sheet showed diagnoses of Bipolar Disorder, Schizoaffective Disorder, Psychosis, and Delusional Disorder.

R111's face sheet showed diagnoses included Glaucoma and Anxiety Disorder.

On 12/9/21 at 9:16 AM, V2 Director of Nursing and V3 Assistant Director of Nursing stated R114's orientation depends on the day. R114 recently had a Stroke. R114 probably can't tell any accurate history besides what happened today. R114's face sheet showed diagnoses of Intracranial Hemorrhage, Encephalopathy, and Transient Ischemic Attack.

On 12/9/21 at 9:16 AM, V2 Director of Nursing and V3 Assistant Director of Nursing stated R115's orientation depends on the day. R115 is not consistently a reliable historian.
R115's face sheet showed diagnoses of Osteoarthritis and Hypertension.

On 12/9/21 at 9:16 AM, V2 Director of Nursing and V3 Assistant Director of Nursing stated R116 needs a formalized assessment to see if she has an official dementia diagnosis. R116 has shown a decrease in cognition evidenced by her behaviors. We've been working with our Psych group regarding her symptoms. R116 was started on an anti-anxiety medicine. She has too much going on. Her family was concerned as well. R116 was feeling lost in her apartment and not sure what she was supposed to do. She needs a lot of cuing to initiate care.
R116's face sheet showed diagnoses of

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S9999	Continued From page 19 Aneurysm of Iliac Artery and gross Hematuria. The facility's 1/9/17 Medication Storage in the Facility Policy showed medication rooms, carts and medication supplies are locked when not in use or in direct view of persons with authorized access. Potentially harmful substance such as urine reagent tablets, household poisons, cleaning supplies, and disinfectants are clearly identified and stored in a locked area separate from medications. The facility's 4/21 storage of Chemicals and Cleaning Compounds Policy showed all chemicals and cleaning compounds are to be stored in locked cabinets or rooms. The facility's 2/19 Policy on Contaminated Sharps showed sharps are discarded in containers that are kept behind a locked door, ie nurse med room, residents locked treatment cupboard, etc. (B)	S9999		