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JAN 22 2013
Division of Health Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355058	A. BUILDING _____ B. WING _____	12/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST HOME INC	1100 E BOULEVARD AVE BISMARCK, ND 58501

(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 For the standard Medicare/Medicaid survey started on 12/03/12 and completed on 12/06/12, the sample included five (5) residents for complete review, sixteen (16) residents for focused review, and three (3) closed records for review.	F 000		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, review of professional reference, review of facility policy, and staff interview, the facility failed to ensure professional standards of care regarding the administration of medications in a timely manner during a random observation of medication pass on 12/04/12. Failure to ensure timely administration of medications may result in residents' experiencing adverse health effects. Findings include: Berman and Snyder, "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 9th ed., Pearson Education, Inc., New Jersey, page 864, states, ". . . Ten 'Rights' of Medication Administration . . . RIGHT TIME . . . Give the medication at the right frequency and at the time ordered according to agency policy. Medications given within 30 minutes before or after the scheduled time are considered to meet the right time standard. . . ."	F 281	F 281 #1 Resident #1 Nurses and CMA's re-educated on medication administration within the appropriate time frame, as well as documentation required when medications are administered outside of the time frame. #2 All Nurses and CMA's re-educated on medication administration within the appropriate time frame as well as documentation required when medications are administered outside of the time frame. #3 Policy titled "Medication Administration and Record Keeping" is being reviewed and revised. Nurses and CMA's will be inserviced 1/8/13 and 1/9/13 regarding the revised policy titled "Medication Administration and Record Keeping". #4 On or before January 10, 2013 #5 Quality Director will monitor the medication pass and observe the Medication Administration Record for compliance with medication administration and documentation weekly x4 and monthly x2. Results will be immediately reported to the	1/10/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cindy Temple | TITLE: Administrator | (X6) DATE: 1/22/13

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 281	Continued From page 1 Review of the facility policy titled "Medication Administration and Record Keeping" occurred on 12/06/12. This policy, dated November 2012, stated, ". . . POLICY: . . . 2. Medications must be given within one hour of the designated administration time. When timely medication administration is not possible, it must be documented and the medication given as soon as possible. When medication has been administered beyond the one hour time frame, place your initials in the appropriate box on the MAR [medication administration record] and circle the initials. Document the reason medications were not administered on the back of the MAR. . . ." Review of Resident #1's medical record occurred on all days of survey. Diagnoses included Alzheimer's dementia, atherosclerosis, constipation, hypertension, persistent back pain, and lower extremity edema. Observation on 12/04/12 at 1:15 p.m. showed a certified medication aide (CMA) (#2) administering medications in the dining room. The CMA stated, "She [Resident #1] hasn't had any pills yet today." The CMA dished up the following medications for Resident #1: *Metoprolol (an antihypertensive) *Tylenol *Imdur (used to treat chest pain) *Risperdal (an antipsychotic) *Senna S (a laxative) *Namenda (used to treat dementia) *Enalapril (an antihypertensive) *Hydrochlorothiazide (a diuretic) *Calcarb with D (a calcium/vitamin D supplement)	F 281	(F 281 continued) Director of Nursing. If concerns are identified immediate corrective action will be implemented. The Quality Director will submit a report of the monitoring results to the QA committee at each scheduled meeting and necessity of further monitoring will be determined.	

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F 281	Continued From page 2 *Plavix (an anticoagulant) Resident #1's MAR showed the Hydrochlorothiazide, Calcarb with D, Enalapril, Tylenol, Senna S, Metoprolol, Namenda, and Risperdal had administration times of 7:00-10:00 a.m. The CMA administered these medications at 1:15 p.m. (over three hours past their scheduled times). During the medication pass, Resident #1 spit out the enalapril, Imdur, Senna S, metoprolol, and Plavix. Although the CMA documented that Resident #1 refused these medications, she failed to identify the reason the medications were late. During an interview on the afternoon of 12/06/12, a supervisory nursing staff member (#1) stated she expected staff to administer medications within an hour of their scheduled times, and if this was not possible, staff were expected to document the reason for the late administration.	F 281	F 309 #1 Resident #1 Nurses and CMA's educated on hypoglycemia and insulin injection timing Resident #'s 1, 6, & 8 nursing staff (Nurses, CMA's, & CNA's) educated on the importance of the resident wearing ordered compression stockings. #2 All nurses, CMA's, and CNA's will be re-educated on hypoglycemia and insulin injection policies. All nurses, CMA's, and CNA's will be re-educated on importance of resident wearing ordered compression stockings.	
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: 1. Based on observation, medical record review,	F 309	#3 Current policies titled "Hypoglycemia, Insulin Reactions, Insulin Shock Treatment Guidelines" and "Insulin Injection Guidelines" will be reviewed and revised. Nurses, CMA's and CNA's will be in-serviced regarding the policies on 1/8/13 and 1/9/13. All residents who wear compression stockings will be assessed by the nurse for daily application and removal of compression stockings and such will be documented on the TAR. All nurses will be educated	1/10/13

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F 309	Continued From page 3 review of professional reference, review of facility policy, and staff interview, the facility failed to ensure 1 of 5 sampled residents (Resident #1) receiving insulin injections received care and services necessary to prevent hypoglycemia. Failure to ensure Resident #1 ate promptly after the administration of a rapid-acting insulin (on 12/04/12) and failure to ensure Resident #1 consumed adequate nutrition to stabilize blood sugar levels after receiving insulin resulted in repeated hypoglycemic episodes which required emergency intervention (i.e. glucose gel and IM Glucagon). Findings include: The Nursing 2011 Drug Handbook, page 1064-1065, stated, ". . . NovoLog . . . ADMINISTRATION . . . Give NovoLog 5 to 10 minutes before the start of a meal. . . . ACTION . . . Onset . . . 15 min [minutes] . . . Peak . . . 1-3 hr [hours] . . . Duration . . . 3-5 hr . . ." Review of the facility policy titled "Hypoglycemia, Insulin Reactions, Insulin Shock Treatment Guidelines" occurred on 12/06/12. This undated policy stated, ". . . Insulin reactions can occur at any time and come on quickly. They are most apt to occur: a. Before meals or if meals are delayed. . . . Peak action times of the insulin. . . . Be alert to the signs and symptoms of an insulin reaction. These include: . . . shaking . . ." Review of Resident #1's medical record occurred on all days of survey. Diagnoses included Alzheimer's dementia and type II diabetes mellitus. The current Minimum Data Set (MDS), dated 11/26/12, identified extensive assistance	F 309	F 309 (continued) regarding this change during in-services 1/8/13 and 1/9/13. #4 On or before January 10, 2013 #5 Quality Director will monitor the Medication Administration Record for compliance with medication administration and documentation, and monitor the TAR for compliance with compression stockings weekly x4 and monthly x2. Results will be immediately reported to the Director of Nursing. If concerns are identified immediate corrective action will be implemented. The Quality Director will submit a report of the monitoring results to the QA committee at each scheduled meeting and necessity of further monitoring will be determined.	

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from one person for eating and a weight loss (not physician-prescribed). Current physician's orders included:
*4 units NovoLog (a rapid-acting insulin) at breakfast
*Sliding Scale NovoLog before meals and at bedtime
*Lantus (a long-acting insulin) 3 units at bedtime
*Accu-checks (blood glucose monitoring) before meals (7:30 a.m., 11:30 a.m., and 5:30 p.m.) and at bedtime (8:00 p.m.)

Observation of medication pass occurred on 12/04/12 at 8:23 a.m. with a nursing staff member (#8). The nurse (#8) checked Resident #1's blood sugar (which was 81 mg/dl [milligrams per deciliter]) and drew up four units of NovoLog insulin. Observation showed the resident in bed wearing her pajamas. The nurse administered the insulin in the resident's abdomen and left the room. At 9:12 a.m. (nearly an hour later), a certified nursing assistant (CNA) (#4) entered the room and assisted Resident #1 with morning cares. During the observation, Resident #1 was visibly shaking. The CNA finished assisting Resident #1 with cares and brought her to the dining room. Observation showed the staff served Resident #1 her breakfast tray at 9:54 a.m. (an hour and a half after she received her insulin injection).

Observation on 12/04/12 at 10:05 a.m. showed Resident #1 did not consume any of her breakfast. A CNA (#4) stated, "She didn't eat anything. Drank a few sips of water and that was it." Observations throughout the morning showed Resident #1 in the living room, dozing off and on in her wheelchair.

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F 309	Continued From page 5 During an interview on 12/04/12 at 12:52 p.m., a nurse (#8) stated she checked Resident #1's blood sugar "around noon" and it was 46. She then gave the resident glucose gel from the emergency kit, and a CNA fed Resident #1 pudding and some juice. At 1:45 p.m., the nurse (#8) checked Resident #1's blood sugar, which measured 193 mg/dl. During an interview on 12/04/12 at 12:52 p.m., a CNA (#4) stated Resident #1 had a low blood sugar before lunch. She also stated, "Well, you know, she hasn't had anything to eat or drink all morning." The CNA also reported Resident #1 was groggy all morning and didn't eat much for lunch. During an interview on the morning of 12/05/12, a nursing staff member (#9) stated she administered Resident #1's NovoLog insulin "around 7:45 [a.m.]." Observation showed Resident #1 did not receive her breakfast tray until approximately 8:50 a.m. (one hour later). Nurses' notes, blood sugar monitoring reports, meal intake reports, and medication administration records (MARs) showed the following previous episodes of hypoglycemia: *12/01/12: ". . . Called into [Resident #1] room at 2100 [9:00 p.m.] resident is unresponsive, color pale, eyes open with fixed glare. Accu check with blood glucose of 43 mg/dl. Glucagon 1 mg IM [intramuscular] given STAT [immediately] per standing orders, phone call to [physician name], orders received. [Resident #1] blood glucose was 145 at 2230 [10:30 p.m.], resident did take one	F 309		

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glass of orange juice . . ." Resident #1's MAR showed staff administered six units of NovoLog insulin (per sliding scale) for a blood sugar of 327 mg/dl at 5:38 p.m. (prior to the evening meal). Meal intake records showed that Resident #1 did not consume any of her evening meal (zero percent).

*11/27/12: The MAR showed a blood sugar of 574 mg/dl 5:30 p.m. A physician ordered a one-time dose of 22 units of NovoLog. At 7:40 p.m., Resident #1's blood sugar was 154 mg/dl. Meal intake records showed that Resident #1 ate 10 percent of her supper meal and none of her bedtime snack. At 11:30 p.m., Resident #1's blood sugar was 46 mg/dl. The record failed to identify any staff intervention after obtaining this reading. At 12:35 a.m., Resident #1's blood sugar was 104 mg/dl.

*11/18/12: The MAR showed a blood sugar of 364 mg/dl 5:30 p.m., and staff administered seven units of NovoLog (per sliding scale). Meal intake records showed Resident #1 did not consume any of her evening meal and 25% of her bedtime snack. At 9:05 p.m., Resident #1's blood sugar was 37 mg/dl. Staff administered one mg of IM Glucagon STAT per physician's order. At 10:05 p.m., Resident #1's blood sugar was 155 mg/dl.

*11/16/12: The MAR showed a blood sugar of 432 mg/dl at 5:45 p.m., and staff administered nine units of NovoLog insulin (per sliding scale). Meal intake records showed Resident #1 consumed 15% of her evening meal and did not consume a bedtime snack. The next recorded blood sugar reading (obtained at 10:00 p.m., not

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F 309	Continued From page 7 8:00 p.m. as ordered by the physician) showed Resident #1's blood sugar was 49 mg/dl. Nurses' notes identified staff gave Resident #1 milk with sugar, and her blood sugar was 96 mg/dl upon recheck. Refer to F312 for additional information relating to Resident #1. 2. Based on observation, medical record review, and staff interview, the facility failed to provide care and services in accordance with physician's orders for 3 of 10 sampled residents (Resident #1, #6, and #8) with TED (Thrombo-Embolic Deterrent) hose/Tenoshape stockings (medically prescribed, tight-fitting stockings used to help improve venous return and decrease edema). Failure to ensure residents wore compression stockings as ordered may result in increased edema and/or blood clot formation. Findings include: - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included lower extremity edema and hypertension. The current Minimum Data Set (MDS), dated 11/26/12, identified extensive assistance from one person for dressing. A physician's order, dated 02/21/12, stated, "(B) [bilateral] Tenoshape garments to be worn daytime/off HS [bedtime]. [DX {diagnosis}: Symptom, edema- L/E {lower extremity} edema]." Observation on 12/04/12 at 9:12 a.m. showed a CNA (#4) assisted Resident #1 with morning cares. The CNA stated, "Your feet are swollen today," to Resident #1. Observation showed both	F 309		

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Resident #1's feet and lower legs were visibly swollen. The CNA failed to apply Resident #1's Tenoshape garments as ordered.

Observations throughout 12/04/12 and 12/05/12 showed staff failed to apply Resident #1's Tenoshape stockings.

Resident #1's CNA care card (used by the CNAs to help direct care) failed to identify the use of the Tenoshape stockings, although the intervention was listed on Resident #1's care plan.

- Review of Resident #8's medical record occurred on all days of survey. Diagnoses included edema and hypertension. The current MDS, dated 10/31/12, identified extensive assistance from one person for dressing. Current physician's orders included "Bilateral knee high Tenoshape stockings, on a.m., off HS."

A physician's progress note, dated 08/13/12, stated, ". . . 1-2 + edema noted to bilateral lower extremities. She does not have TED hose one [sic] . . .ASSESSMENT/PLAN . . . Peripheral edema. I did write orders for bilateral knee high Tensoshape [sic] stockings on in the morning and off at h.s. We will see if this helps improve her lower extremity edema. . . ." The CNA care card listed the intervention- "Tenoshapes on in AM."

Observation on 12/04/12 at 8:43 a.m. showed a CNA (#10) assisted Resident #8 with morning cares. The CNA failed to apply Resident #8's Tenoshape stockings.

- Review of Resident #6's medical record occurred on all days of survey. Diagnoses

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F 309	Continued From page 9 included edema, chronic kidney disease, hyperlipidemia, and hypertension. The resident's current quarterly MDS, dated 11/27/12, identified extensive assistance of one person for dressing. Resident #6's current physician's orders stated, "Knee high ted hose (on in a.m., off at HS). Once a day." The current care plan for Resident #6 stated problems of "Decreased cardiac output related to a diagnoses of hypertension, dyslipidemia" and "ADL [activities of daily living] deficit related to decreased tolerance for physical activity" with approaches of "Ted hose on in am; off at hs," and "Dressing and undressing: Assist." Observations throughout the survey showed facility staff failed to apply Resident #6's TED hose.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility staff failed to provide the necessary assistance for 2 of 5 sampled residents (Resident #1 and #14) identified by the facility as requiring assistance with eating. Failure to provide Resident #1 with assistance at mealtimes and	F 312	F 312 #1 Resident #1 and #14 nursing staff re-educated on the importance of providing assistance and encouragement to enhance the consumption of nutrition for those residents that require assistance. #2 All nursing staff will be re-educated on the importance of providing assistance and encouragement to those residents that need assistance in order to enhance the consumption of nutrition. #3 All residents who require a supplement or assistance with eating will be assessed for meal/supplement consumption and need for assistance. Development of a policy titled "Nutrition Consumption" to ensure identification of residents needing assistance. All nursing staff will be in-serviced 1/8/13 and 1/9/13 regarding the policy. #4 On or before January 10, 2013	1/10/13

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F 312	Continued From page 10 with nutritional supplements between meals, placed the resident at risk for continued weight loss. Failure to provide Resident #14 with mealtime assistance placed the resident at risk for inadequate food and fluid intake and loss of dignity. Findings include: - Review of Resident #14's medical record occurred on December 03-06, 2012. Diagnoses included Alzheimer's dementia and a recent urinary tract infection (11/07/12). The record identified the facility sent Resident #14 to the hospital on 10/18/12 for a blood transfusion, and the resident returned on 10/19/12. Resident #14 experienced a functional decline upon her hospital return and, after monitoring the resident for ten days, the facility determined Resident #14 failed to return to her baseline level of functioning. A significant change Minimum Data Set (MDS), dated 10/29/12, identified Resident #14 as cognitively intact and required limited assistance from one person for eating. The current MDS, dated 12/03/12, identified Resident #14 displayed moderately impaired cognition and required limited assistance from one person for eating. Observations of Resident #14 in the dining room (DR) throughout the survey showed: *12/03/12 at 5:42 p.m. - Resident #14 seated in her wheelchair (w/c) in the DR and after numerous attempts observation showed the resident unable to reach the food items (chicken burger and french fries) on her plate due to the plate being too far away. At 5:50 p.m., observation showed a staff nurse (#5) sat down	F 312	(F 312 continued) #5 Quality Director will monitor for compliance with "Nutrition Consumption" policy weekly x4 and monthly x2. Results will be immediately reported to the Director of Nursing. If concerns are identified immediate corrective action will be implemented. The Quality Director will submit a report of the monitoring results to the Hydration/Nutrition Committee and the QA committee at each scheduled meeting and necessity of further monitoring will be determined.	

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at the table and provided verbal cuing and physical assistance to Resident #14.

*12/04/12 at 8:46 a.m. - Resident #14 seated in her w/c in the DR and grabbing for and touching her tablemate's cloth napkin. Observation showed numerous staff members present in the DR, but no staff member sitting at or near Resident #14. At 9:00 a.m., observation showed Resident #14 placed an ink pen into her cereal bowl filled with milk, and her tablemate removed the ink pen from the bowl. Observation showed corn flakes located on Resident #14's pants and lap.

*12/04/12 at 12:45 p.m. - Observation showed Resident #14 placed her fork into her water glass, pushed her w/c back and away from the DR table and failed to eat her lunch meal. At 12:50 p.m., a staff member (#12) stopped at the table, positioned Resident #14's w/c up to the table, locked the w/c brakes, and provided verbal encouragement to the resident to eat her lunch. At 12:53 p.m., an unidentified staff member provided a container of ice cream to Resident #14 and failed to remove the lid. Observation showed Resident #14 attempted to pull off the lid without success.

*12/05/12 at 12:40 p.m. - Resident #14 seated in her w/c in the DR and observed placing her fingers into her baked beans. Observation showed numerous staff members present in the DR and no one provided physical assistance or verbal cuing/encouragement to Resident #14.

Failure to provide verbal encouragement and cuing and/or physical assistance during meals did not ensure Resident #14 received adequate nutrition and maintained her dignity during the meal service.

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	355058	A. BUILDING _____ B. WING _____	12/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST HOME INC	1100 E BOULEVARD AVE BISMARCK, ND 58501

(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 312	Continued From page 12	F 312		

- Review of Resident #1's medical record occurred on all days of survey. Diagnoses included Alzheimer's dementia and a history of weight loss. The current MDS, dated 11/26/12, identified extensive assistance from one person for eating and a weight loss (not physician-prescribed). Resident #1 experienced a weight loss of 22 pounds from June 2, 2012 through November 24, 2012.

A Dietary Progress Note, dated 11/08/12, stated, ". . . Resident continues to experience weight loss. . . . Added Lyons Shake supplement 6oz [ounces] bid [twice per day] between meals to add additional calories. . . ." The medication administration record (MAR) listed administration times of 10:00 a.m. and 2:00 p.m.

Observations throughout the morning of 12/04/12 showed staff failed to assist with/offer Resident #1 her supplement shake. At 12:52 p.m., a CNA (#4) confirmed Resident #1 had not had anything to eat or drink all morning, except "a few sips of water at breakfast."

Observations throughout the afternoon of 12/04/12 showed Resident #1 asleep in her recliner until 4:17 p.m., at which time a CNA (#4) assisted Resident out of bed. At approximately 5:30 p.m., staff brought Resident #1 to the dining room for supper. Staff failed to assist with/offer Resident #1 a supplement shake during this time.

Observation on 12/05/12 at 9:04 a.m. showed Resident #1 asleep at the dining room table with a breakfast tray in front of her. Observations throughout the meal showed staff failed to

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F 312	Continued From page 13 encourage/assist Resident #1. At the end of the meal, Resident #1 consumed approximately one-fourth of a caramel roll and one-fourth of a piece of toast. Failure to provide assistance with meals/supplements to Resident #1 (who cannot independently feed herself or access nutritional supplements) may result in further weight loss and a decreased nutritional status.	F 312	F 323 #1 Staff on 3rd floor re-educated on the importance of securely stowing chemicals kept in resident areas. #2 All staff will be in-serviced by 1/10/13 on the importance of securely stowing chemicals kept in resident areas and will be in-serviced on the policy titled "Safe Chemical Storage." #3 Review and revise policy titled "Safe Chemical Storage". #4 On or before January 10, 2013 #5 Quality Director will monitor compliance weekly x4 and monthly x2. Results will be immediately reported to the Director of Nursing. If concerns are identified immediate corrective action will be implemented. The Quality Director will submit a report of the monitoring results to the QA committee at each scheduled meeting and necessity of further monitoring will be determined.	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policies and procedures, review of material safety data sheets, review of warning labels on containers of chemicals, and staff interview, the facility staff failed to maintain an environment free of hazardous chemical supplies on 2 of 3 floors of the facility (first and third floor). Accessible hazardous chemicals places cognitively impaired and wandering residents at risk for accidents/injury. Findings include: Review of the facility's policy and procedure	F 323		1/10/13

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F 323	Continued From page 14 (dated 07/18/11) titled "SAFE CHEMICAL STORAGE" occurred on 12/04/12. This policy/procedure stated, "PURPOSE: To ensure that residents are safe from accidental exposure to hazardous chemicals. 1. Units in the facility are provided with a safe chemical storage area. . . . KEY FOR SAFE CHEMICAL STORAGE: . . . 2. Keep cabinet doors locked at all times. . . ." - Observation on 12/04/12 at 9:30 a.m. and 12:35 p.m., showed the door to the entrance of the third floor bathing room/area (located across from room number 308) to be unlocked. Observation showed no staff members present in the area. The unlocked room contained the following chemical: Buckeye Sanicare Quat-128. Observation on 12/04/12 at 10:05 a.m. and 10:15 a.m., showed the door to the entrance of the third floor bathing room/area (located across from room number 352) to be wide open and no staff members present in the area. A sign on the outside of the door stated, "KEEP DOOR LOCKED WHEN NOT IN USE." Observation, at 12:40 p.m. and at 1:05 p.m., showed this door to be unlocked and no staff members present in the area. The room contained the following chemical: Buckeye Sanicare Quat-128. Observation on 12/04/12 12:50 p.m., showed the door to the entrance of the third floor soiled utility room (located by the entrance to the special care unit) to be unlocked. No staff members were within view of the door to this room. Inside the soiled utility room, an unlocked cabinet attached to the wall contained the following chemicals: Crew Clinging Toilet Bowl Cleaner, Challenge Antibacterial Cleaner, and BioMatic Bacteria	F 323		

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F 323	Continued From page 15 Waste Digester. A counter, beneath the unlocked cabinet, contained the following chemicals: Buckeye Tenacity and BioMatic Bacteria Waste Digester. Review of the material safety data sheets, on the above-stated chemicals, identified the following: *Buckeye Sanicare Quat-128 - ". . . Corrosive. Causes irreversible eye damage and skin burns. Harmful if swallowed or inhaled. . . ." *Crew Clinging Toilet Bowl Cleaner - ". . . DANGER. CORROSIVE, CAUSES SKIN AND EYE BURNS. HARMFUL OR FATAL IF SWALLOWED. . . ." *Challenge Antibacterial Cleaner - ". . . Very hazardous in case of eye contact (irritant, corrosive) . . . Harmful if swallowed . . ." *Buckeye Tenacity - ". . . Moderate eye and slight skin irritant. . . ." *BioMatic Bacteria Waste Digester - ". . . Keep out of reach of children . . . May cause eye irritation. . . ." During interview, on the afternoon of 12/04/12, an administrative maintenance staff member (#11) identified the expectation would be for chemicals to be stored in a locked area. - Observation on 12/05/12 at 4:45 p.m., showed the following hazardous chemicals, labeled with warnings, in an unlocked cabinet in the activity room located on first floor: *One bottle, "Brasso - Danger: Harmful or fatal if swallowed. Harmful if inhaled." *One bottle, "Mr. Clean - Causes eye irritation. Avoid contact with eye." *One spray bottle, "Vanish - Eyes: get immediate medical attention. Ingestion: if	F 323		

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F 323	Continued From page 16 conscious, drink plenty of fluids." During an interview on 12/05/12 at 5:30 p.m., an administrative dietary staff member (#7) confirmed the hazardous chemicals should be in a locked cabinet.	F 323		