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	495359	A. BUILDING _____ B. WING _____	C 06/14/2017

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DOGWOOD VILLAGE OF ORANGE COUNTY HEALTH AND REHAB	120 DOGWOOD LANE ORANGE, VA 22960

(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 An unannounced Medicare/Medicaid standard survey was conducted 6/13/17 through 6/14/17. One complaint was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 164 certified bed facility was 154 at the time of the survey. The survey sample consisted of 21 current Resident reviews (Residents #1 through #21) and 5 closed record reviews (Residents #22 through #26).	F 000		
F 151 SS=D	483.10(b)(1)(2) RIGHT TO EXERCISE RIGHTS - FREE OF REPRISAL (b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. (b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. (b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on a group resident interview, facility document review and clinical record review, it was determined that the facility staff failed to allow residents to exercise their right to vote for	F 151	1. The facility has established corrective action for not allowing residents #18, #19, and #20 to exercise their right to vote in the most recent election. Correction was made by policy revision and staff education within the Social Services Department on 6/22/17. 2. The other residents of the facility have the potential to be affected by this deficient practice. 3. The Social Services Department was in-serviced on 6-26-17 by the Director of Customer Relations on the importance of encouraging the residents to	

VDH/OLC

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Admin — (X6) DATE: 6-30-17

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 151	Continued From page 1 three of 21 current residents in the survey sample, Residents #18, #19, and #20. During the group interview it was determined that the facility staff failed to offer to assist or assist Residents #18, #19, and #20 to exercise their right to vote. The findings include: Resident #18 was admitted to the facility on 6/21/13 with diagnoses that included but were not limited to: polyneuropathy (a group of neuromuscular disorders (1)), sleep apnea, high blood pressure, chronic obstructive pulmonary disease, hypothyroid, gastroesophageal reflux disease and vitamin D deficiency. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date (ARD) of 5/23/17, coded the resident as scoring a 15 on the BIMS (brief interview for mental status), indicating that she was cognitively intact to make daily decisions. Resident #19 was admitted to the facility on 3/28/17 with diagnoses that included but were not limited to: gastroesophageal reflux disease, insomnia, sleep apnea, depression and obesity. The most recent MDS assessment, an annual assessment, with an ARD of 3/28/17, coded the resident as scoring a 15 on the BIMS (brief interview for mental status), indicating that she was cognitively intact to make daily decisions. Resident #20 was admitted to the facility on 1/19/17 with diagnoses that included but were not	F 151	exercise their right to vote in state and local elections. A policy revision was made to include providing voting information to the residents via flyers, newsletters, postings, during resident council as well as individual meetings during voting months. Upon admission, residents will be interviewed to determine if they are currently registered to vote and in which county or town that they are registered. 4. To ensure compliance the Social Service Department will audit the new admissions to the facility weekly for 4 weeks then monthly for 3 months to ensure that the residents have been informed about their voting rights.	7/10/17

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limited to: fractures of the upper and lower arm and ribs, muscle weakness, cellulitis, end stage renal disease, restless leg syndrome, anemia, depression and high blood pressure.

The most recent MDS assessment, a quarterly assessment, with an ARD of 4/20/17, coded the resident as scoring a 15 on the BIMS (brief interview for mental status), indicating that she was cognitively intact to make daily decisions.

A group interview was conducted on 6/13/17 at 2:00 p.m. with four cognitively intact residents. A primary election was taking place on this day for the offices of governor and lieutenant governor. When asked if they voted in the election that day, all four residents stated, "No, no one said anything about the election today." Resident #18 stated that she had seen it on the news. When asked if they would have wanted to vote in the elections that day, three of the four residents, Residents #18, #19 and #20 all stated that they would have voted.

An interview was conducted with other staff member (OSM) #1, a social worker, on 6/14/17 at 2:03 p.m. When asked how the residents vote in an election, OSM #1 stated, "We assist them with getting an absentee ballot or we take them to the polls ourselves. The voting people come to the senior living (assisted living facility next door) and our people (residents in nursing home) go over there." When asked how she was involved, OSM #1 stated, "If a resident requests to vote, I assist them." When asked how all of the residents are made aware of the elections and how to vote, OSM #1 stated, "We post flyers and tell them about it in Resident Council." When asked if the residents had the opportunity to vote in the

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primary election yesterday (6/13/17), OSM #1 stated, "None of my residents requested to vote."

An interview was conducted with OSM #5, the director of social services, on 6/14/17 at 2:10 p.m. When asked how the residents vote at this facility, OSM #5 stated, "We have a list of folks who want to vote and we assist them with absentee ballots or take them to the polls." When asked if the residents were offered the opportunity to vote in yesterday's election, OSM #5 stated, "I assumed they had the chance to vote." At this time, the group interview discussion was shared with OSM #5. A copy of the policy on resident voting was requested from OSM #5.

An interview was conducted with OSM #6, a social worker, on 6/14/17 at 2:12 p.m. When asked if any residents voted in the primary election yesterday, OSM #6 stated, "No one asked me." When asked how residents know who to go to if they want to vote, OSM #6 stated, "They talk about it in Resident Council." When asked if all residents go to Resident Council, OSM #6 stated, "No." OSM #6 stated, "In mid-October the registrar comes to the facility and registers anyone that wishes to vote." When asked if anyone went around to every resident, who is capable of voting, to ask if they wanted to vote in the primary election, OSM #6 stated, "No, we didn't do that."

The "Resident Council Minutes" for 3/28/17, 4/24/17 and 5/23/17 were reviewed. There was no documentation regarding the primary election on 6/13/17.

An interview was conducted with administrative staff member (ASM) #1, the executive director,

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F 151	Continued From page 4 on 6/14/17 at 2:21 p.m. When asked about the process at the facility for assisting residents to vote, ASM #1 stated he had only been there for a week. ASM #1 stated, "In other facilities I've worked in the activities department coordinates the process. They get the registrar to come to the facility, offer absentee ballots and if needed, the resident is taken to the polls." At this time, the group interview was shared with ASM #1 and ASM #1 was made aware of the above concern. The facility policy, "Voting Rights" documented, "(Name of facility) residents are encouraged to exercise their right to vote in local, state and national elections. Policy Interpretation and Implementation: 1. The facility will help resident expressing a desire to exercise their right to vote achieve that right. 2. The Social Services Department will help residents with: a. voter registration; b. obtaining absentee ballots; and/or c. obtaining transportation to voting sites. 3. All requests for voting information should be directed to the Social Services Department." No further information was provided prior to exit. (1) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3987657/	F 151		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review	F 279	1. The facility has established corrective action for resident #14 to ensure that Care Plans are created based on triggered CAA's (Care Area Assessments) that are identified and need to be care planned regarding	

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F 279	Continued From page 5 and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)-	F 279	Communication and Vision, this was completed on 6/13/17. 2. The other residents of the facility identified with triggered CAA's for Communication and Vision have the potential to be affected by the same deficient practice. A review of current residents with these triggered CAA's was conducted by the RAI Director on 6/21/17. 3. In-services for the IDT on the Care Planning Process regarding the use of triggered CAA's for the creation of the Care Plan was conducted on 6/22/17. 4. The RAI Director and/or designee will conduct an audit of all comprehensive assessments with CAA triggered in Communication and Vision to ensure completed weekly for 4 weeks, then monthly x 3 months to ensure that the Care Plan has been created for any reason necessary Communication and Vision needs. Variances will be investigated /corrected and responsible staff will be re-educated as appropriate. The	

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F 279	Continued From page 6 (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to develop a comprehensive care plan from the CAA (care area assessment) section of the MDS (minimum data set) for one of 26 residents in the survey sample, Resident #14. The facility staff failed to develop Resident #14's care plan for the CAA triggered areas of visual function and communication on the annual MDS assessment with an assessment reference date (ARD) of 1/3/17. The findings include: Resident #14 was admitted to the facility on 1/18/16. Resident #14's diagnoses included but were not limited to: chronic kidney disease and dry eye syndrome. Resident #14's most recent MDS, a quarterly assessment with an ARD (assessment reference date) of 4/4/17 coded the resident's cognition as severely impaired.	F 279	audits will be analyzed by the DON or designee for trends and report to monthly QAPI for additional oversight and recommendations.	7/10/17

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Resident #14's most recent comprehensive MDS was an annual assessment with an ARD of 1/3/17. Section V documented an "X" beside the care areas of visual function and communication, and documented the areas would be care planned. Resident #14's comprehensive care plan initiated on 1/19/16 failed to document any information regarding visual function or communication.

On 6/13/17 at 5:15 p.m., a list of resident document requests was given to ASM (administrative staff member) #2 (the director of nursing). The list documented a request for Resident #14's vision and communication care plans. On 6/14/17 at 7:00 a.m. upon this surveyor's entrance into the facility, a copy of Resident #14's comprehensive care plan was lying on a table in the surveyor conference room. The care plan contained care plans for visual function dated 6/13/17 and communication dated 6/13/17.

On 6/14/17 at 11:18 a.m., an interview was conducted with RN (registered nurse) #1 (MDS coordinator). RN #1 stated she was responsible for completing the CAA section of MDS assessments and creating care plans based on the CAA section. RN #1 stated if a care area triggers and the MDS documents the area will be care planned then the area should be care planned. When asked if visual function and communication should have been care planned for Resident #14, RN #1 stated, "Yes." RN #1 confirmed the care plan did not contain visual function or communication care plans prior to this surveyor's request on 6/13/17. RN #1 stated the care plan was corrected after this surveyor's

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F 279	Continued From page 8 request. On 6/14/17 at 1:59 p.m. ASM #1 (the Executive Director) and ASM #2 were made aware of the above concern. The facility policy titled, "RAI (Resident Assessment Instrument) AND CARE PLANNING PROCESS" documented, "For all comprehensive MDS assessments the CAT or Care Area Trigger will be checked if specific questions completed in the MDS were answered a specific way. For each triggered Care Area, indicate if addressed in Care Plan by checking box provided on MDS. This must be completed within 7 days of completing the MDS and CAA's..." No further information was presented prior to exit.	F 279		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.	F 280	1. The facility has accomplished corrective action for resident #6 to ensure the Care Plan was updated based on identified resident to resident behaviors that may have affected the residents, this was corrected on 6/13/17. 2. The other residents of the facility with identified resident to resident behavior have the potential to be affected by the same deficient practice. A review of current residents with known resident to resident behaviors was conducted by	

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F 280	Continued From page 9 (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the	F 280	the Social Service department on 6/22/17. 3. In-services for the IDT on Care Planning Process regarding the updating of the Care Plan were conducted on 6/22/17. 4. The RAI Director and/or designee will conduct an audit of any known resident to resident behaviors weekly for 4 weeks and then monthly for 3 months to ensure Care Plans have been updated timely for any necessary approach or intervention. Variances will be investigated /corrected and responsible staff will be re-educated as appropriate. The audits will be reviewed by the DON or designee for trends and report to monthly QAPI for additional oversight and recommendations.	7/10/17

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F 280	Continued From page 10 resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined that facility staff failed to review and revise the comprehensive care plan for one of 26 residents in the survey sample, Resident #6. The facility staff failed to update Resident #6's comprehensive care plan after a resident to resident altercation that occurred on 11/8/16. The findings include: Resident #6 was admitted to the facility on 10/2/14 and readmitted on 7/22/16 with diagnoses that included but were not limited to chronic diastolic heart failure, high blood pressure, vascular dementia with behavioral	F 280		

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disturbance, type two diabetes, and major depressive disorder. Resident #6 was coded as being severely impaired in cognitive function scoring 7 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #6 was coded as requiring limited assistance with one person physical assist with transfers; supervision with walking, locomotion and eating; and extensive assistance with one person physical assist with dressing, toileting and personal hygiene.

Review of Resident #6's clinical record revealed the following nursing note dated 11/8/16: "Resident was returning to his room on unit when he was hit in back on right side and back of right arm by another resident. No injuries noted at this time. Resident assessed, no injuries noted at this time, resident denies pain, vitals: 97.9 (temp), 68 (pulse), 20 (respirations), 129/67 (blood pressure), 96 % (percent oxygen) on room air. RP (Responsible party), MD (medical doctor), and Unit manager aware. Resident was redirected to come to social area at this time, resident calm with no behaviors noted at this time."

The next nursing note dated 11/8/16, documented the following: "Resident is on follow up incident, bruise following event of being struck on 11/8/16 by another resident. Resident had no c/o (complaints) of pain or distress..."

Review of a social work note dated 11/9/16, documented the following: "resident (sic) does not recall yesterday's events-overall mood and affect appear at baseline- up and down hall and to mdr (main dining room) for meals per his norm."

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(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
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Review of Resident #6's care plans dated 10/04/2014 and 12/30/16, did not address the incident on 11/8/16.

On 6/14/17 at 12:00 p.m. an interview was conducted with OSM (other staff member) #1 (a social worker). OSM #1 was asked to describe the role she plays when a resident is struck by another resident. OSM #1 stated as soon as she is made aware a resident has been struck by another resident she assesses the resident. OSM #1 stated she interviews the resident to see if they have any psychosocial changes, mood changes, if/how the resident was affected by the event and ensures the resident feels safe. OSM #1 stated she also updates the resident's care plan.

On 6/14/17 at 12:05 p.m., an interview was conducted with RN (registered nurse) #3, the unit manager of East Main Unit. When asked about the process followed by staff when a resident is struck by another resident, RN #3 stated she will separate the residents, ensure that the residents are safe, assess the residents and then put an intervention into place such as 15 min checks for the aggressor. RN #3 stated the care plan of the incident would be updated for both residents. When asked who was responsible for updating the care plan, RN #3 stated that the social worker usually updates the care plan, but nurses can update the care plan as well.

On 6/14/17 at 1:33 p.m., further interview was conducted with RN #3. RN #3 stated that she could not find where the care plan was updated for Resident #6 after the 11/8/16 incident.

On 6/14/17 at 1:45 p.m., ASM (administrative

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	495359	A. BUILDING _____ B. WING _____	C 06/14/2017

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F 280	Continued From page 13 staff member) #1, the executive director and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. Facility policy titled, "Comprehensive Person-Centered Care Planning," documents in part, the following: "15) The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans: a) When requested by the resident/resident representative. b) When there has been a significant change in the resident's condition. c) When the desired outcome is not met; d) When the resident has been readmitted to the facility from a hospital stay; and e) At least quarterly and after each OBRA MDS assessment." No further information was presented prior to exit.	F 280		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.	F 323	1. The facility accomplished corrective action for the isolated incident to protect resident safety where one bottle of disinfectant 2.0 solution was observed stored in an unlocked cabinet in a spa room. That item was removed on 6/13/17. 2. The other residents of the facility have the potential to be affected by the same deficient practice. The facility inspected the other spas on 6/14/17 to ensure that any other chemicals stored were stored	

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F 323	Continued From page 14 (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that facility staff failed to store chemicals in a safe manner for one of five spa rooms. Facility staff stored a bottle of Disinfectant Cleaner 2.0 solution in an unlocked cabinet in one of five resident spa rooms. The findings include: On 6/13/17 at 12:00 p.m., observation of the facility was conducted. On 6/13/17 at 12:18 p.m., observation was made of the spa room on the West Main unit. The spa room door was unlocked. No residents were in the spa room. A bottle of disinfectant 2.0 solution was observed stored in an unlocked cabinet above the toilet. 200 milliliters (ml) of liquid was left in the bottle. On 6/13/17 at 12:20 p.m., OSM (other staff member) #3, a housekeeping staff member, walked into the spa room. An interview was conducted with OSM #3 at this time. When asked how chemicals should be stored, OSM #3 stated that housekeeping always locks up their chemicals. When asked who was responsible for ensuring chemicals were locked up, OSM #3	F 323	securely in a locked cabinet. 3. The Environmental Services and Nursing staff will be in-serviced by 7/10/17 on the importance of maintaining resident safety. 4. To ensure compliance the Director of Environmental Services or designee will round daily for weekly for 4 weeks and then monthly for 3 months to ensure disinfectants are not left in an unlocked cabinet. Variances will be investigated /corrected and responsible staff will be re-educated as appropriate. The audits will be reviewed by the DON or designee for trends and report to monthly QAPI for additional oversight and recommendations.	7/10/17

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F 323	Continued From page 15	F 323		

stated that the Director of Housekeeping was responsible. OSM #3 stated that CNAs (certified nursing assistants) and nurses also had access to the housekeeping chemicals/cleaners. OSM #3 stated, "I didn't leave this bottle in here. I lock mine up." OSM #3 stated, "This bottle is not supposed to be here." OSM #3 took the bottle of disinfectant out of the spa room.

On 6/14/17 at 1:18 p.m., an interview was conducted with OSM #2, the Director of Housekeeping. When asked who was responsible for ensuring chemicals were locked and stored properly; OSM #2 stated that housekeeping and maintenance made rounds of the facility in the morning, afternoon and evening to check for chemicals/cleaners that are not stored properly. When asked who had access to chemicals from housekeeping, OSM #2 stated that the housekeeping department was the only ones with a key to the housekeeping closet, but nursing and other staff could request to use a cleaner. OSM #2 stated that chemicals should never be stored in an unlocked cabinet especially in a resident area. When asked if Disinfectant 2.0 solution could potentially be harmful to a resident, OSM #2 stated, "I would assume so. My staff (housekeeping) know to lock up their chemicals."

On 6/14/17 at 1:45 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

Review of the Disinfectant Cleaner 2.0 solution label documented the following: "Precautionary statements hazards to humans and animals WARNING: causes substantial eye injury. Harmful if absorbed through the skin. Do not get

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F 323	Continued From page 16 in eyes or on clothing. Wear protective eyewear (goggles, face shield or safety glasses.) Remove contaminated clothing and wash before reuse. Avoid contact with skin. Wash thoroughly with soap and water after handling." Review of the MSDS (Material Safety Data Sheet) for Disinfectant Cleaner 2.0, documents in part, the following: "Hazards identification...Emergency overview...Causes eye and skin irritation. Harmful if absorbed through the skin. Combustible liquid and vapor. May cause respiratory tract irritation...Avoid contact with eyes, skin and clothing. Avoid breathing vapors, spray or mists. Keep away from heat, sparks, and flame...Potential acute health effects: Eyes: Severely irritating to eyes. Skin: irritating to skin. Inhalation: Moderately irritating to the respiratory system. Ingestion: No known significant effects or critical hazards." Facility policy titled, "Housekeeping Reminders," documents in part, the following: "...Keep chemicals locked out of resident's reach."	F 323		