STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	824519	A. BUILDING _____ B. WING _____	12/13/2023

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OPTALIS HEALTH AND REHABILITATION OF CANTON	7025 LILLEY ROAD CANTON, MI 48187

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F0000 SS=	INITIAL COMMENTS Optalis Health and Rehbilitation of Canton was surveyed for an Abbreviated survey on 12/13/23. Intakes: MI00136543, MI00136560, MI00136584, MI00136849, M100136861, MI00137393, MI00137404, MI00137410, MI00137413, MI00137532, MIO0137947, MI00138014, MI00138272, MI00138606, MI00138740, MI00138968, MI00139301, MI00139559, MI00139742, MI00139751, MI00139813, MI00139825, MI00140000, MI00140042, M100140151, MI00140212, M100140237, M100140351, MI00140374, MI00140483, M100140508, MI00140707, MI00141039, M100141158, MI00141215, and MI00141380 Census= 118	F0000		
F0584 SS= E	Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of	F0584	1. The Cherry Hill shower rooms affected by the deficient practice were cleaned. 2. Current residents have the potential to be affected by this deficient practice. The shower rooms were audited throughout the facility for cleanliness and any areas found corrected. 3. The In- service Manager/designee will educate the Nursing staff and housekeeping staff on the policy for Showering regarding maintaining the shower rooms in a clean and sanitary manner between showering residents. 4. The In-service Manager/designee will audit communal shower rooms and 5 showers within resident rooms to ensure cleanliness 5 times a week for 4 weeks then weekly for 3	1/8/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 01/05/2024

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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	the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: This citation pertains to MI00140483. Based on observation, interview, and record review, the facility failed to ensure the Cherry Hill shower room was maintained in a clean and sanitary manner, resulting in the potential to spread harmful pathogens and residents' environment not being clean and homelike. Findings include: It was reported to the Stage Agency that resident shower rooms were not clean. During an interview and observation of the Cherry Hill shower room on 12/11/23 at 12:31 PM with Certified Nurse Aide (CNA) "H", used tissue paper, that appeared somewhat dry, was observed on top of a shower chair seat/commode, wedged underneath the seat/commode, and lying on the bottom front frame of the shower chair. CNA "H" said the tissue paper looked like it was stained with urine. CNA "H" stated, "The shower		months. Results to be shared in QAPI for further guidance. Director of Nursing is responsible for achieving and maintaining compliance. Date of Compliance January 8, 2024	

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	chair should have been cleaned after use." On 12/12/23 at 12:52 PM, the Director of Nursing said that shower rooms should be cleaned up after use. A review of a facility policy titled, "Showering", dated 2/1/03, revealed in part, "Clean the shower room, leaving it in order and ready for use."			
F0656 SS= D	Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(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)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and	F0656	• E1- Resident 420 was discharged from the facility on 9/26/23 and no longer resides in the facility. An updated Wound Care Guideline was initiated on 10/18/23. Wound Care binders were provided at the Nurses stations as a Tool to coordinate Wound Care and promote prompt initiation of treatment plan. • E2- All residents residing in the facility who developed a pressure skin injury are determined to be like residents. An initial audit of residents with pressure injury was completed to ensure plan of care reflects appropriate treatment plan in a timely manner. • E3- The facility Wound Care Protocol was reviewed and deemed appropriate. Nurses were educated on the Wound Care protocol. • E4- Nurse Managers or Designee will complete random audit of 2 residents who have pressure ulcers to ensure treatment plan is initiated promptly and is reflected in the care plan. The audit will occur 3x/week x 4 weeks, then monthly x2 months. Findings will be submitted to the QAPI committee for further review and recommendations. • E5- The DON is responsible for substantial compliance. Date of compliance- January 8, 2024.	1/8/2024

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	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. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: This citation pertains to intake MI00139751. Based on interview and record review, the facility failed to develop a skin alteration care plan for one resident (R420) of five residents reviewed for pressure ulcers, resulting in the potential for the resident to not receive the proper interventions/treatment. Findings include: A review of R420's EMR (Electronic Medical Record) revealed R420 was admitted to the facility on 9/13/23 and discharged from the facility on 9/26/23. R40 had medical diagnoses that included: disorder of muscle, type 2 diabetes, and encephalopathy (disease that disrupts brain function causing confusion and altered mental status). A review of R420's MDS (Minimum Data Set) dated 9/18/23 revealed R420 had a BIMS (Brief Interview of Mental Status) score of 15/15 (cognitively intact). According to the MDS, R420 had the possibility of developing pressures but at			

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	the time of the MDS, R420 did not have any pressure ulcers. A review of R420's orders revealed the following orders: - "Wound consult- right buttock (order date 9/16/23)" - "Cleanse right buttock with normal saline apply with dry dressing (order date 9/16/23)" A review of R420's care plan dated 9/14/23 revealed, "Diagnosis: At risk for alteration in skin integrity related to: COVID, pneumonia, generalized weakness, hyperlipidemia (elevated lipid levels in the body), chronic obstructive pulmonary disease (chronic lung inflammation that obstructs air flow), lung cancer with metastasis to brain (lung cancer that spreads to the brain), pulmonary embolism (blockage of a lung artery), and chronic back pain." A review of the comprehensive care plan did not reveal an updated, resident specific care plan for the developed skin alteration once the orders for a wound consult and wound care treatment were placed on 9/16/23. On 12/13/23 at 11:50 AM, during an interview, the DON (Director of Nursing) verified that she did not see a care plan related to R420's pressure ulcer wound. The DON said she expected the nurses to put in a general skin alteration care plan with a focus that is specific to the resident.			
F0677 SS= D	ADL Care Provided for Dependent Residents §483.24(a)(2) 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	F0677	• E1- Resident 416 & 426 no longer reside in the facility, while 403 remains in the facility. R403's care plan was updated to reflect shower preference and shower schedule. R403's preferred shower was provided.	1/8/2024

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	hygiene; This REQUIREMENT is not met as evidenced by: This citation pertains to MI00136584, MI00138968, MI00140212, and MI00140483. Based on interview and record review, the facility failed to provide showers according to resident's preference and/or on their scheduled shower days for three (R403, R416, and R426) of fifteen residents reviewed who were dependent on staff for performance of activities of daily living (ADLs), resulting in untimely and unmet care needs regarding personal hygiene. Findings include: It was reported to the State Agency that residents were not receiving regular showers. Resident #416 On 12/11/23 at 10:00 AM, a review of complaint intake related to Resident #416 (R416) documented resident was not showered in a timely manner. Record review of R416's face sheet revealed admitted to facility on 6/29/23 diagnoses included Covid-19, fall, diabetes mellitus type 2, Atrial fibrillation, hypertension, high cholesterol, psychotic disorder, congestive heart failure, and disorder of muscle. Review of the "Minimum Data Set" (MDS) dated 6/30/23 for R416 revealed a "Brief interview for Mental Status "BIMS of 8/15 moderate cognitive impairment and physical help in part of bathing activity, one-person physical assist.		Remedial education on providing preferred showers was initiated and completed. • E2- All residents residing in the facility who are dependent on staff for bathing/shower are determined to be like residents. An audit of the shower schedules and preferences were completed on all like residents. Shower schedule tasks were updated as appropriate. • E3- The facility policy on ADL care was reviewed and deemed appropriate for education. CNAs were educated on the ADL care policy with a focus on providing care based on plan of care and preferences. • E4- Nurse Managers or Designee will randomly audit 2 residents who are dependent on staff for showers/bathing to ensure (1) shower preferences are considered if appropriate and (2) resident showers were received per schedule. The audit will occur 3x/week x 4 weeks, then monthly x2 months. Findings will be submitted to the QAPI committee for further review and recommendations. • E5- The DON is responsible for substantial compliance. Date of compliance- January 8, 2024.	

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	On 12/12/23 at 10:13 AM the director of Nursing (DON) was queried about the frequency of showers for R416. Shower sheets were requested. Record review of the "ADL" care plan-created date of 6/30/2023 documented, "Will receive the assistance necessary to meet ADL needs ...Interventions: Assist to bathe/shower as needed." In an interview with the DON on 12/12/23 at 1:45 PM the DON stated there are no records of a shower log or showers/baths given for R416, "It looks like the task was never triggered by nursing." When the DON was queried about the expected frequency of showers, she said, "Showers are to be given twice a week and should be documented." Resident #403 On 12/11/23 at 12:45 PM, Unit Manager/Licensed Practical Nurse (UM/LPN) "D" was interviewed and stated, "We are still trying to get showers in order. Staff complete shower sheets when showers are given and shower refusals should be documented." UM/LPN "D" was able to produce one shower sheet for Resident #403 (R403) which was dated 11/2/23. UM/LPN "D" stated, "I don't see any more shower sheets (for R403)." UM/LPN "D" said she had been told that R403's family prefers R403 to receive showers. Resident's preferences and/or family's preferences for showers should be honored. CNA documentation of showers/baths given to R403 during the last 30 days were reviewed with UM/LPN "D" and revealed that bed baths were given on 11/13/23, 11/16/23, 11/20/23, 11/23/23, 11/27/23, 11/30/23, 12/4/23, and 12/7/23. There were no documented showers given to R403 during the last 30 days. A review of nursing notes did not reveal documentation of			

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	shower refusals during the last 30 days. A review of the Admission Record for R403 documented an admission date of 12/31/22. R403's diagnoses included Alzheimer's disease, major depressive disorder, and legal blindness. A MDS assessment dated 11/19/23 documented severe cognitive impairment. A MDS assessment dated 5/19/23 documented dependence upon staff for showers/baths. Record review of R403's "ADL self-care deficit" care plan revised on 11/27/23 documented, "Assist to bathe/shower as needed." Resident #426 A review of the Admission Record for Resident #426 (R426) documented an admission date of 9/16/23. R426 discharged from the facility on 10/31/23. R426's diagnoses included cancer of the vulva (external female genitals), lungs, bladder, and bone, moderate protein-calorie malnutrition, congestive heart failure, type 2 diabetes mellitus, and dementia. A MDS assessment dated 10/30/23 documented severe cognitive impairment. A MDS assessment dated 9/23/23 documented dependence upon staff for showers/baths. Record review of R426's "ADL self-care deficit" care plan created on 9/18/23 documented, "Assist to bathe/shower as needed." A review of shower documentation for R426 during October 2023 provided by the DON revealed R426 was to receive a shower/bath on Tuesdays and Fridays. R426 received a bed bath on 10/3/23 and 10/20/23. There was no documentation regarding why R426 did not receive a shower/bath as scheduled on 10/6/23, 10/17/23, 10/24/23, and 10/27/23. On 12/12/23 at 10:50 AM, the DON stated, "It's the patient's right to have their preferences			

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	honored." The DON said when a resident cannot speak for themselves, we should have a voice for the resident. Regarding R403's family, the DON said the family member wants what was best for R403 and "it is my expectation that (R403) gets a shower." Record review of the facility policy titled "Activities of Daily Living (ADL)" issued 8/21/23 revised 12/7/23 revealed in part "Appropriate care and services will be provided for residents who are unable to carry out ADL independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: Hygiene (bathing, dressing, grooming, and oral care)."			
F0692 SS= D	Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by:	F0692	E1- R426 no longer resides in the facility. R426 experienced weight loss despite interventions to slow down expected weight loss related to diagnosis of cancer with mets. Poor monitoring of meal assistance and meal intake resulted from the identified practice. Remedial education on documentation of meal assistance and meal intake was initiated and completed. E2- All residents residing in the facility who are at risk for nutrition are determined to be like residents. An audit of the meal assistance documentation on all like residents was completed and showed compliance range is above 90%. Appropriate evaluation of residents at nutrition risk was initiated. E3- The facility policy on Documentation and Nurse Aide Responsibilities Workflow was reviewed and deemed appropriate for education. CNAs were educated on the facility policies on Documentation and Nurse Aide Responsibility Workflow with a focus on Meal assistance.	1/8/2024

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	This citation pertains to MI00140212. Based on interview and record review, the facility failed to consistently document the provision of meal assistance for one resident (R426), deemed to be at nutrition risk, out of eleven residents reviewed for food intake/feeding assistance, resulting in the potential for additional nutrition concerns to go undetected and compromise in nutritional status. Findings include: It was reported to the State Agency that facility staff failed to provide meal assistance for a resident. A review of the Admission Record for Resident #426 (R426) documented an admission date of 9/16/23. R426 discharged from the facility on 10/31/23. R426's diagnoses included cancer of the vulva (external female genitals), lungs, bladder, and bone, moderate protein-calorie malnutrition, congestive heart failure, type 2 diabetes mellitus, and dementia. A Minimum Data Set assessment dated 10/30/23 documented severe cognitive impairment. A MDS assessment dated 9/23/23 documented extensive one-person physical assistance for eating. Record review of R426's "Resident is at nutrition risk (related to) cancer with mets (metastasis - cancer that has spread), mod PCM (moderate protein calorie malnutrition), impaired skin integrity, dementia, CHF (congestive heart failure), poor appetite, dependent for feeding, weight loss PTA (prior to admission)" care plan created on 9/18/23 documented in part, "Assistance with meals as needed", "Red napkin - (patient) needs to be fed", and "Monitor intake and record q (every) meal." A review of September 2023 and October 2023 documentation of meal assistance provided to		E4- DON, RD or Designee will randomly audit 3 residents in the facility who are at risk for nutrition to ensure that their meal assistance has been documented. The audit will occur 2x/week x 4 weeks, then monthly x2 months. Findings will be submitted to the QAPI committee for further review and recommendations. E5- The DON is responsible for substantial compliance. Date of compliance- January 8, 2024	

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	R426 by CNAs (Certified Nurse Aides) documented no evidence of eating support provided for the following meals: Breakfast: 9/22/23, 9/25/23, 9/28/23, 9/30/23, 10/1/23, 10/2,23, 10/9/23, 10/22/23 to 10/25/23, 10/27/23, 10/28/23, 10/30/23 Lunch: 9/20/23, 9/22/23, 9/25/23, 9/27/23 9/28/23, 9/30/23, 10/1/23, 10/2/23, 10/9/23, 10/22/23 to 10/28/23, 10/30/23, 10/31/23 Dinner: 9/21/23, 9/22/23, 9/26/23, 9/28/23, 9/30/23, 10/2/23, 10/5/23, 10/8/23, 10/9/23, 10/13/23 to 10/15/23, 10/20/23, 10/23/23, 10/28/23 to 10/31/23 A review of nutrition notes documented in part the following: 1. Nutrition Assessment dated 9/19/23: "...(R426) also has vulvular cancer with mets. Not currently receiving treatment...(past medical history) includes mod PCM...Recommend liberalize to diabetic diet. Her appetite is poor. Food prefs (preferences) obtained. Provided with menu to make meal selections. Per daughter she needs to be fed and requires encouragement to initiate feeding...She has been losing weight for several months...Skin - open area to sacrum and groin..." 2. Nutrition progress note dated 10/6/23: "RD (Registered Dietitian) following r/t (related to) weight change...She needs to be fed..." On 12/12/23 at 10:18 AM, the Director of Nursing (DON) was queried and said the "red napkin" designation means the resident requires meal assistance. The dietitian assesses the patient			

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OPTALIS HEALTH AND REHABILITATION OF CANTON	7025 LILLEY ROAD CANTON, MI 48187

(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
	and determines who needs the red napkin. The DON added that Nurses can do it, but usually it is the dietitian. The CNA's should see it in the plan of care for the resident because that is how they know what type of care the resident needs. R426's care plans were reviewed with the DON. The DON acknowledged that R426 needed to be fed by staff and there was missing documentation that R426 was receiving meal assistance according to her plan of care. On 12/12/23 at 1:20 PM, RD "F" stated R426 was considered at nutrition risk because she "came into the facility with diagnosis of moderate protein calorie malnutrition." RD "F" said R426 had dementia and was very weak.			
F0812 SS= E	Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i) (1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i) (2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: This citation pertains to MI00140483.	F0812	1. No food borne illness resulted from the identified practice. All Nourishment rooms and refrigerators were immediately cleaned. All open food items in fridge were date-labeled, expired/undated food were removed. 2. All residents have the potential to be affected. All refrigerators have been audited to ensure no food items are without proper identification including but not limited to the resident's personal identifier. 3. The In-service Manager/Designee will educate the nursing staff related to policy "Safe storage of Food". 4. The In-service Manger/Designee will complete audits to ensure food items brought in from the outside will have sufficient labeling in the refrigerator. Audits will be done on Nutrition room refrigerators to be completed 5 times/week for 4 weeks then weekly for 3 months. Results to be shared in QAPI for further guidance. 5. Director of Nursing is responsible for achieving and maintaining compliance. Date of Compliance January 8, 2024.	1/8/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	Based on observation, interview, and record review, the facility failed to properly clean resident refrigerators, date-label opened food, and remove expired/undated food from two resident refrigerators, resulting in the potential for food borne illness. Findings include: It was reported to the State Agency that the nourishment rooms were not cleaned. On 12/11/23 at 8:48 AM the Medbridge Nourishment Room was observed with Unit Manager Nurse (UM) "C". The following was noted: - The rug in front of the ice machine was soiled and dirty. UM "C" stated, "The rug needs to be vacuumed." - The soap dispenser near the handwashing sink was empty. - The outside of the resident refrigerator was soiled. UM "C" stated, "It's very dirty." The inside of the refrigerator was soiled with a dried red fluid. UM "C" stated, "It needs to be cleaned." - A 48 oz. container of cranberry juice cocktail was opened and undated in the resident refrigerator. - The following food items stored in the resident refrigerator were identified as belonging to a resident by UM "C": 1. Two bags of an identified resident's food was undated. 2. One container of food with no resident identification or date.			

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	3. Two containers of an identified resident's food was undated 4. One bag of food with no resident identification or date. 5. One disposable container with no resident identification or date. 6. Opened container of a sports drink with no resident identification or date. - The contents of the resident refrigerator freezer included: 1. A fast food chocolate shake with no resident identification or date. 2. A frozen pot pie with no resident identification. UM "C" stated the freezer was "very dirty." On 12/11/23 at 9:00 AM the Cherry Hill Nourishment Room was observed with Unit Manager Licensed Practical Nurse (UM/LPN) "D". The following was noted: - The soap dispenser near the handwashing sink was empty. - The following food items stored in the resident refrigerator were identified as belonging to a resident by UM/LPN "D": 1. Two bags of opened shredded cheese were undated. 2. One package of sliced cheese was undated. 3. 12 oz. container of mayonnaise was undated.			

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	4. One round container of food was undated 5. One box of pizza with four slices that remained was undated. 6. Four-pack of cheesecake with no resident identification. 7. Three containers of food in a bag with no resident identification or date. - The following food items were opened and undated in the resident refrigerator: 1. 46 oz. container of cranberry juice cocktail 2. 46 oz container of tomato juice 3. 89 oz. container of ice tea with a use-by-date of 10/24/23 4. 89 oz. container of orange juice with a use-by-date of 11/10/23 On 12/12/23 at 12:52 PM, the Director of Nursing stated, "Everyone should be monitoring the resident refrigerators. Housekeeping is supposed to clean the resident refrigerators." A review of the facility policy titled, "Safe Storage of Food Provided by Families No. 5014 Department of Dietary", dated 3/8/21 documented in part the following: - When families bring in food for our residents, the facility will provide safe storage as defined by the US Food Code. All food items provided by families will be labeled and dated, stored properly, and used within an acceptable timeframe.			

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	- Each item will be clearly labeled with resident's name and room number, and the current date before being refrigerated. - All refrigerated food is to be used within 72 hours or discarded. - If food items are not labeled, they will be discarded. - Once daily, Housekeeping is responsible for cleaning of the refrigerator and for review of dated items stored in the refrigerator. According to the 2013 FDA Food Code: - Section 3-101.11, Safe, Unadulterated, and Honestly Presented: Food shall be safe, unadulterated, and, as specified under § 3-601.12, honestly presented. - Section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (C) nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. - Section 4-602.13, Nonfood-Contact Surfaces, Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues.			