

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155198	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/07/2014
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NAME OF PROVIDER OR SUPPLIER  MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>This visit was in conjunction with a Post Survey Revisit (PSR) to the Investigation of Complaint IN00145137 completed on March 27, 2014.</p> <p>Survey dates: April 29, and 30. May 1, 2, 5, and 7, 2014.</p> <p>Facility number: 000105 Provider number: 155198 AIM number: N/A</p> <p>Survey team: Gloria Bond, R.N.--Team Coordinator Janet Stanton, R.N. Michelle Hosteter, R.N. Sandra Nolder, R.N.</p> <p>Census bed type: SNF--83 Residential--59 Total--142</p> <p>Census payor type: Medicare--30 Other--112 Total--142</p>	F000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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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F000329 SS=D	<p>Residential Sample: 7</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review was completed by Tammy Alley RN on May 13, 2014. 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to quantitatively monitor specific behaviors to justify the use of an anti-anxiety and anti-psychotic medication for 1 resident who was</p>	F000329	<p><b>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</b> The interdisciplinary</p>	05/31/2014

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	<p>receiving these medications. This deficiency impacted 1 of 5 residents reviewed for Unnecessary Medications. (Residents #2).</p> <p>Findings include:</p> <p>1. The clinical record for Resident #2 was reviewed on 5/2/14 at 12:17 P.M. Diagnoses included, but were not limited to, malignant neoplasm breast, lung cancer with metastases, generalized pain, macular degeneration, depression, and anxiety.</p> <p>The admission MDS (Minimum Data Set) assessment, dated 4/2/14, indicated the resident had a BIMS (Brief Interview for Mental Status) score of "10" (with a score of 8 to 12 indicating moderately impaired cognitive status). The resident indicated she had mood symptoms of little interest or pleasure in doing things, feeling down, depressed, or hopeless, had trouble falling or staying asleep, and feeling tired or having little energy. The MDS assessment indicated the resident had no symptoms of psychosis (hallucinations or delusions), and no behavioral symptoms. The assessment indicated the resident was receiving an anti-anxiety and anti-depressant medication.</p>		<p>team reviewed the behavior plans for Resident #2. A medication review was conducted and gradual dose reduction requested. <b>How other Residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</b> All residents identified with problematic behaviors have the potential to be affected by the alleged deficient practice. Staff education provided on the Behavior Management Policy and Procedure. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b> The Behavior Management Policy was reviewed by the interdisciplinary team with recommended addendums approved by the facility medical director. Staff education will be conducted on the new Behavior Management Policy and Procedure. <b>How the corrective action will be monitored to ensure the deficient practice will not recur?</b> A behavior management audit will be conducted weekly x 4 weeks, then bi-weekly x2 months, then monthly thereafter. The results of the audits will be reviewed at the monthly QAPI meeting for recommendations and compliance. (Attachments: Notice of</p>	

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	<p>Admission medications on 3/20/14 included the following: (Previous start 7/31/13)--Xanax (an anti-anxiety medication) 0.25 mg. (milligrams) 1 tablet three times a day. (Previous start date 7/31/13)--Xanax 0.25 mg. 3 tablets at HS (hour of sleep)</p> <p>The March, 2014 physician's order recap (recapitulation) sheet included the following: Order date 3/20/14--Xanax 0.25 mg. two times daily (at 8:00 A.M., and 1:00 P.M.) Order date 3/20/14--Xanax 0.25 mg. (3 tablets) at bedtime 9:00 P.M.</p> <p>Subsequent physician orders included: 3/22/14--May have 0.25 mg. Alprazolam (Xanax) 1 tablet PRN (as needed) 3 times/day. 3/23/14--St. Vincent Hospice services as of 3/20/14 4/22/14--Schedule Xanax 0.25 mg. every 2:00 A.M. 4/24/14--Seroquel 25 mg. po every HS--Dx. Hallucinations</p> <p>A Physician progress note, dated 4/29/14, indicated "New concerns: Hallucinating; no behavioral issues; eats 50%; moderate pain. Urinary retention--discontinued bladder scan. She was not retaining urine but holding it as she was afraid to push the button to ask for help; apparently she</p>		<p>In-service, Content of training, Behavior Management Policy and Procedure, Audit tool) <b>Compliance Date:</b> May 31, 2014</p>	

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	<p>pushed "the wrong" button once inadvertently and "a group of people" ran into her room scaring her. This apprehension caused her to try and make it to the bathroom herself and she experienced some falls with that. Most of the time this is happening around 2:00 A.M.; we now have her on a toileting schedule that includes 2:00 A.M., and so far she has not had any more falls. No longer wears hearing aid--communication is via dry erase board at her bedside."</p> <p>There was no additional information from the physician related to the "hallucinations."</p> <p>Progress notes from 4/1/14 included, but were not limited to, the following: 4/10/14--"increased forgetfulness, complaining of meds [medications] not been administered when she had already taken meds." 4/12/14--"Res [resident] has had non episodes of crying or tearfulness." 4/13/14--"Complained of shortness of breath; oxygen SATs [saturation levels] 88-89% on room air. New order from Hospice for morphine." 4/14/14--"Resident calm." 4/17/14--"Had period of anxiousness and restlessness. Removed oxygen per self. Oxygen SAT 88%. Oxygen replaced and morphine given."</p>			

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	<p>4/18/14--"SATs 78% on room air. Oxygen started. After one hour, SATs at 90%."</p> <p>4/20/14--"Had increased anxiety and restlessness noted. Removed nasal cannula. SATs 86%. Given 2 AM antianxiety [medication] and PRN morphine for shortness of breath."</p> <p>4/20/14 at 11:23 P.M.--"Quiet, no anxious complaints, no complaints of dysuria, urgency, etc."</p> <p>4/24/14 at 11:27 P.M.--"[Family member ] visiting at bedside, playing cards. Informed [family member] of new order for Seroquel every bedtime for hallucinations."</p> <p>There were no progress notes from Nursing or Social Service that indicated the resident was experiencing hallucinations prior to the order for the Seroquel. "Anxiousness" was only documented occasionally among many entries indicating the resident was "calm."</p> <p>On 5/2/14 at 1:00 P.M., a "Behavior Log" binder was found for "2 A" on top of chart carousel. There were no behavior monitoring sheets for this resident for the Xanax or Seroquel.</p> <p>In an interview on 5/2/14 at 1:13 P.M., the Social Service Director indicated</p>			

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	<p>behavior monitoring forms were in the Behavior Log book, and there were no entries in the computer/electronic health record for behaviors. She indicated she was the one to put the forms in the log book. When she opened the binder, there were no monitoring forms for Resident #2 for either the Xanax or the Seroquel. She indicated the resident didn't have a "Behavior Care Plan" for behaviors, but she would review the clinical record. She was requested to locate the on-going monitoring, listing the specific behaviors used to justify the use of the Xanax and the Seroquel medications.</p> <p>On 5/2/14 at 1:36 P.M., the Social Service Director provided a "Behavior Plan for Resident" sheet for Resident #2, listing a behavior of "Hallucinations." There was no description of the type of hallucinations the resident was displaying (visual or auditory). She indicated the form had been on her desk, and she had not filed it yet in the Behavior Log book. She indicated the resident had not displayed any episodes of hallucinations since starting the Seroquel because "the staff had not given her any" documentation related to episodes of hallucinations. She indicated she was not sure how many episodes the resident had experienced prior to being prescribed the anti-psychotic medication--"maybe a</p>			

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F000371 SS=F	<p>couple, I'd have to check my notes." The SSD indicated she did not have any monitoring sheets for the Xanax.</p> <p>At the final exit on 5/7/14 at 12:00 P.M., no other documentation was provided for review, related to the resident's "hallucinations," or quantitative monitoring of specific behaviors to justify the use of the anti-psychotic and anti-anxiety medications.</p> <p>3.1-48(a)(3) 3.1-48(a)(4) 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to ensure foods stored in the freezers and cooler were properly labeled with an open date. This had the potential to affect 83 of 83 residents served food from the main facility kitchen, which prepared all the food and distributed it to the rest of the campus.</p> <p>Findings include:  A tour of the main facility kitchen was</p>	F000371	<p><b>What correctiveaction will be accomplished for those residents found to have been affected bythe deficient practice?</b> No residents were identified to be affected by this allegeddeficient practice. <b>How will otherresidents having the potential to be affected by the same deficient practice beidentified and what correction actions will be taken?</b> Those resident s who would have selected those itensidentified have the potential to be affected by this</p>	05/31/2014			

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	<p>conducted on 4/29/14 at 10:00 A.M., with the Director of Food and Beverage Services and the Executive Chef in attendance.</p> <p>The protein freezer was observed with the following food items with no open date observed on them:</p> <p>One--three gallon tub of Vanilla flavored ice cream.</p> <p>One--three gallon tub of Vanilla flavored ice cream. This ice cream tub also had a lid that was torn in multiple places and the ice cream could be seen through the torn areas on the lid. Ice crystals had formed on top of the ice cream.</p> <p>Two--three gallon tubs of Rainbow flavored sherbet were opened.</p> <p>One--three gallon tub of Peppermint Stick flavored ice cream.</p> <p>12 frozen Beer Batter Cod and 25 pieces of battered Shrimp Tenders were opened and taped closed laying in a box labeled Battered Shrimp Tenders.</p> <p>30 sausage links were lying in a box labeled Sausage Links with the bag split open. The sausage links had ice crystals formed on them.</p>		<p>alleged deficient practice. The policy and procedure for food safety in receiving and storage was immediately re-enforced with the dietary staff.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b></p> <p>Staff will be in-serviced on proper food labeling and storage by 5/30/14. Dietary management will perform daily audits for two weeks, weekly audits for 90 days, then monthly audits thereafter to ensure food is properly labeled and stored.</p> <p><b>How will the corrective action be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place?</b></p> <p>The Director of Food &amp; Beverage, Executive Chef and Dietician will conduct and document audits. Results of the audits will be reviewed at the monthly QAPI meetings for recommendations and compliance.</p> <p><b>(Attachments downloaded: In-service announcement, Food Storage Policy and Procedure, Pre and Post-test, Audit tool.)</b></p> <p><b>Compliance Date: May 31, 2014</b></p>	

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	<p>Two pounds of breaded Chicken tenders were opened in a bag that was tied closed with a knot lying on top of a box by the freezer door.</p> <p>The vegetable cooler was observed with two pounds of shredded carrots lying in the bottom of a zip lock type closure bag placed on a shelf in the cooler with the bag open. There was no open date on the bag.</p> <p>The vegetable cooler was observed to have had the number of pints of milk that was over the use by date.</p> <p>One pint of white whole milk was sitting in a milk crate with pints of white skim milk with a use by date of 4/15/14.</p> <p>50 pints of white whole milk was sitting in a milk crate under 3 other crates of a variety of flavors of milk with the use by date of 4/21/14.</p> <p>15 pints of white whole milk was sitting in a milk crate with pints of white skim milk with a use by date of 4/21/14.</p> <p>Two pints of white whole milk was sitting in a milk crate with pints of white skim milk with a use by date of 4/28/14.</p>			

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	<p>The vegetable freezer was observed with one-half of a bag of Beer Battered Onion Rings that were opened and tied closed, but had no open date.</p> <p>During an interview on 4/29/14 at 10:55 A.M., the Executive Chef indicated the ice creams, sherbets, Cod, Shrimp Tenders, sausage links, Chicken tenders, shredded Carrots, and Beer Battered Onion Rings should have had an open date on them when these food items were opened. He indicated he did not know how long the lid had been damaged on the ice cream and it would not be used because it could have been freezer burnt from being exposed to the cold. He indicated the sausage links should have been placed in a zip lock bag when they were opened instead of being left in the opened bag. He indicated the bag of carrots should have been closed. He indicated the pints of milk were missed when the milk delivery person came to the facility to delivery the new milk supply. He indicated these pints of milk were out of date and could not be used.</p> <p>During an interview while touring the kitchen, the Executive Chef indicated the Health Care part of the facility had satellite kitchenettes and the food from the main facility kitchen was prepared and delivered to these kitchenettes. The</p>			

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F000428 SS=D	<p>food was then served to the residents from these kitchenettes.</p> <p>A current policy titled "Food Storage" was provided on 5/5/14 at 9:36 A.M., by the Director of Food and Beverage Services. The policy indicated, "Policy: It is the policy of the community to store foods under proper conditions of sanitation, temperature, light, moisture, and security...13. Food and non-food supplies are to be clearly labeled. 14. Leftover foods are labeled, dated, immediately placed under refrigeration and used within 72 hours or discarded...16..All exposed foods should be stored tightly covered...."</p> <p>3.1-21(g)(3)</p> <p>483.60(c) DRUG REGIMEN REVIEW, REPORT</p>				

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	<p><b>IRREGULAR, ACT ON</b></p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on interview and record review, the facility failed to follow up on pharmacy recommendations in a timely manner for 1 of 5 residents reviewed for medications. (Resident #127)</p> <p>Findings include:</p> <p>The record review for Resident # 127 was completed on 5/2/14 at 11:15 A.M. Diagnoses included, but were not limited to, diabetes, high blood pressure, low sodium, and dementia.</p> <p>The resident had a Physician's order dated 4/16/14, that indicated the following orders due to weight loss :Prostat twice daily and a Pharmacy Medication Review to be done.</p> <p>The progress notes indicated that the Registered Dietician and the IDT (Interdisciplinary Team) reviewed her on 4/29/14 and indicated, "...had recent significant weight loss, she lost 11.9% of her total body weight in 180 days. She continues to have a poor appetite and to</p>	F000428	<p><b>What correctiveactions will be accomplished for those residents found to have been affected bythe deficient practice?</b> The medication review recommendations were reviewed by the attending physician for Resident #127. New orders were obtained. <b>How other Residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective action will be taken?</b> All residents receiving a medication regime review have the potential to be affected by the alleged deficient practice. Staff education conducted on the policy for medication regimen review.</p> <p><b>What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur?</b> The Consultant Pharmacist reviewed the policy for medication regimen reviews with the Director of Nursing. The "Request for Medication Regimen Review" form has been initiated and a tracking system implemented.</p>	05/31/2014

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	<p>require encouragement to eat..."</p> <p>A request was made to the Assistant Director of Nursing (ADoN) on 5/5/14 at 10:50 A.M., for any information regarding the follow up from the Pharmacist from the Physician's order written on 4/16/14 regarding Pharmacy Medication Review due to weight loss.</p> <p>The ADoN indicated on 5/5/14 at 2:45 P.M., this is the information she had to provide at this time. A document titled, " Pharmacy Medication Regimen Review " dated 4/18/14 which indicated, "...Resident is noted to have experienced unplanned weight loss and had requested a medication regimen review. She receives Pravastatin 40 milligrams daily, which can cause GI (gastrointestinal) issues and anorexia (lack of desire to eat) in elderly residents. Low dose Remeron might be an option to consider, however, her sodium has been very low recently (125 on 4/9/14). She also had issues with hyperglycemia, however, her blood sugars are markedly improved over the past 2 days. Recommendation: Please evaluate Pravastatin as potentially contributing to her weight loss, and consider a trial off...Physician's response: I accept the recommendation above please implement as written.-there was a handwritten note that indicated:</p>		<p>The staff members have been educated on the medication regimen review policy. <b>How the correctiveaction will be monitored to ensure the deficient practice will not recur?</b> A medication regimen review audit will be conducted weekly x4 weeks, then bi-weekly x2 months, then monthly thereafter. The results of the audits will be reviewed at the monthly QAPI meeting for further recommendationsand compliance. (Attachments: In-service notice, Contents of training material, audit tool) <b>Compliance Date May 31, 2014</b></p>	



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NAME OF PROVIDER OR SUPPLIER  MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260
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	<p>conducted on 4/29/14 at 10:00 A.M., with the Director of Food and Beverage Services and the Executive Chef in attendance.</p> <p>The protein freezer was observed with the following food items with no open date observed on them:</p> <p>One--three gallon tub of Vanilla flavored ice cream.</p> <p>One--three gallon tub of Vanilla flavored ice cream. This ice cream tub also had a lid that was torn in multiple places and the ice cream could be seen through the torn areas on the lid. Ice crystals had formed on top of the ice cream.</p> <p>Two--three gallon tubs of Rainbow flavored sherbet were opened.</p> <p>One--three gallon tub of Peppermint Stick flavored ice cream.</p> <p>12 frozen Beer Batter Cod and 25 pieces of battered Shrimp Tenders were opened and taped closed laying in a box labeled Battered Shrimp Tenders.</p> <p>30 sausage links were lying in a box labeled Sausage Links with the bag split open. The sausage links had ice crystals formed on them.</p>		<p>affected by this alleged deficient practice. The policy and procedure for food safety in receiving and storage was immediately re-enforced with the dietary staff. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b> Staff will be in-serviced on proper food labeling and storage by 5/30/14. Dietary management will perform daily audits for two weeks, weekly audits for 90 days, then monthly audits thereafter to ensure food is properly labeled and stored. <b>How will the corrective action be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place?</b> The Director of Food &amp; Beverage, Executive Chef and Dietician will conduct and document audits. Results of the audits will be reviewed at the monthly QAPI meetings for recommendations and compliance. <b>(Attachments downloaded: In-service announcement, Food Storage Policy and Procedure, Pre- and Post-test, Audit tool.)</b> <b>Compliance Date: May 31, 2014</b></p>	

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	<p>Two pounds of breaded Chicken tenders were opened in a bag that was tied closed with a knot lying on top of a box by the freezer door.</p> <p>The vegetable cooler was observed with two pounds of shredded carrots lying in the bottom of a zip lock type closure bag placed on a shelf in the cooler with the bag open. There was no open date on the bag.</p> <p>The vegetable cooler was observed to have had the number of pints of milk that was over the use by date found in the cooler:</p> <p>One pint of white whole milk was sitting in a milk crate with pints of white skim milk with a use by date of 4/15/14.</p> <p>50 pints of white whole milk was sitting in a milk crate under 3 other crates of a variety of flavors of milk with the use by date of 4/21/14.</p> <p>15 pints of white whole milk was sitting in a milk crate with pints of white skim milk with a use by date of 4/21/14.</p> <p>Two pints of white whole milk was sitting in a milk crate with pints of white skim milk with a use by date of 4/28/14.</p>			

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	<p>The vegetable freezer was observed with one-half of a bag of Beer Battered Onion Rings that were opened and tied closed, but had no open date.</p> <p>During an interview on 4/29/14 at 10:55 A.M., the Executive Chef indicated the ice creams, sherbets, Cod, Shrimp Tenders, sausage links, Chicken tenders, shredded Carrots, and Beer Battered Onion Rings should have had an open date on them when these food items were opened. He indicated he did not know how long the lid had been damaged on the ice cream and it would not be used because it could have been freezer burnt from being exposed to the cold. He indicated the sausage links should have been placed in a zip lock bag when they were opened instead of being left in the opened bag. He indicated the bag of carrots should have been closed. He indicated the pints of milk were missed when the milk delivery person came to the facility to delivery the new milk supply. He indicated these pints of milk were out of date and could not be used.</p> <p>During an interview while touring the kitchen, the Executive Chef indicated the Residential part of the facility had a satellite kitchenette, but no food was prepared there. He indicated the main</p>			

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	<p>facility kitchen prepared the food then it was brought over to the kitchenette and served to the residents.</p> <p>A current policy titled "Food Storage" was provided on 5/5/14 at 9:36 A.M., by the Director of Food and Beverage Services. The policy indicated, "Policy: It is the policy of the community to store foods under proper conditions of sanitation, temperature, light, moisture, and security...13. Food and non-food supplies are to be clearly labeled. 14. Leftover foods are labeled, dated, immediately placed under refrigeration and used within 72 hours or discarded...16..All exposed foods should be stored tightly covered...."</p>			