STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495262	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shenandoah Nursing Home	339 Westminister Drive Fishersville, VA 22939

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. 41449 Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to conduct a quarterly assessment timely for one resident (Resident #46 - R46), in a survey sample of 22 residents. The findings included: For R46, the facility staff failed to conduct a quarterly MDS (minimum data set - an assessment tool) in a timely manner. On 5/29/24, during a clinical record review, according to the MDS tab, R46 had a quarterly MDS assessment scheduled with an ARD (assessment reference date) of 5/11/24. The MDS assessment was noted to be incomplete and in-process. On 5/29/24 at 1:07 p.m., an interview was conducted with registered nurse #1 (RN #1), who was the MDS coordinator. RN #1 stated that MDS are to be completed within 14 days of the ARD, and acknowledged that R46's assessment was late. The MDS Coordinator also confirmed that they do follow the RAI (resident assessment instrument) manual from CMS (Centers for Medicare and Medicaid Services). CMS provides a manual titled, Long-Term Care Facility Resident Assessment Instrument 3.0 User 's Manual, Version 1.18.11, dated October 2023, with instructions regarding the timing of MDS assessments. According to the table on pages 2-17 through 2-20, the MDS Completion Date is to be no later than the ARD +14 calendar days. Therefore, R46's MDS should have been completed by 5/25/24. On 5/29/24 at approximately 4:15 p.m., during an end of day meeting, the facility administrator and director of nursing were made aware of the above findings. No additional information was provided.

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on observation, staff interview and clinical record review, the facility staff failed to develop a comprehensive care plan for one of twenty-two residents in the survey sample (Resident #30). The findings include: Resident #30 had no plan of care developed regarding use of a remote pacemaker monitoring device. Resident #30 (R30) was admitted to the facility with diagnoses that included anxiety, seizure disorder, diabetes, respiratory failure, cerebral infarction with hemiplegia, atrial fibrillation with cardiac pacemaker, heart failure, and gastroesophageal reflux disease. The minimum data set (MDS) dated [DATE] assessed R30 with severely impaired cognitive skills. R30's clinical record documented a cardiology consult dated 8/21/23. This consult documented the status of the resident's pacemaker as, .Battery life estimated at 2.1 yrs. [years]. Continue to monitor via home remote and follow up in person in one year . R30's plan of care (revised 3/5/24) documented the resident had a pacemaker but included no problems, goals, and/or interventions regarding use/care of a remote monitoring device. On 5/29/24 at 11:03 a.m., the registered nurse (RN #2) caring for R30 was interviewed about the pacemaker and the monitoring device referenced in the cardiology consult. RN #2 stated she was not aware R30 had a remote monitoring device. Accompanied by RN #3, R30's bedside table was observed. RN #2 located a base unit that was identified as the pacemaker monitoring device. RN #2 was interviewed about a plan of care regarding use of the monitoring device. RN #2 reviewed R30's plan of care and stated the monitoring device was not on the plan and there were no interventions listed regarding use/care of the device. On 5/29/24 at 11:19 a.m., the MDS coordinator responsible for care plans (RN #1) was interviewed about R30's pacemaker monitoring device. RN #1 reviewed R30's plan of care and stated that the pacemaker was listed but there was nothing on the care plan about use/care of the remote monitoring device. On 5/29/24 at 11:22 a.m., the director of nursing (DON) was interviewed about R30's pacemaker monitor. The DON stated that he confirmed that the device was working but that there was nothing on the plan of care regarding the monitoring device. This finding was reviewed with the administrator, DON and regional consultant during a meeting on 5/29/24 at 4:10 p.m. No additional information was provided.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 41449 Based on observation, resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to review and revise the care plan for one resident (Resident #46 - R46), in a survey sample of 22 residents. The findings included: For R46, the facility staff failed to review and revise the care plan to address a stage III pressure ulcer to R46's left heel. On 05/28/24 at 12:10 p.m., an interview was conducted with R46. During the interview, it was observed that R46 had a bandage to the left foot. When asked, R46 reported he had a sore on the heel and said, They removed the dead skin from it, and it hurt. R46 went on to say that dead skin was removed and described it as being a black disc, that was removed. On 05/29/24 at 10:53 a.m., a clinical record review was performed of R46's chart. The area was first identified on 1/24/24 and the wound specialist noted the area as a DTI (deep tissue injury). According to the wound specialist note dated 3/6/24, the wound had progressed and was being staged as an unstageable pressure wound. The note read in part, . 3.8 (length) x 5.0 (width) x 0.2 cm (depth), with 90% stable eschar (dead, non-viable tissue) and 10% granular tissue . The wound specialist note dated 5/7/24, read in part, . Left heel stage 3 PI [pressure injury] . performed selective debridement of left heel wound(s) . Review of R46's care plan, with a review date of 5/23/24, had the following goal, 1/15/24 discolored area to L [left] heel will resolve without complications through next review. There was no indication within the care plan that indicated the pressure wound had progressed to a stage III. On 5/29/24 at 1:07 p.m., an interview was conducted with RN #1 (registered nurse), who was the MDS coordinator. RN #1 stated, Care plans are a resource of the resident and what needs to be looked out for and what needs to be addressed. RN #1 went on to explain that care plans are reviewed and updated for . acute changes daily, we go through the orders and update as needed, and then quarterly is an overall review. During the above interview, RN #1 was asked if a resident had a pressure wound that required debridement would this be on the care plan. RN #1 said, Yes. RN #1 accessed R46's care plan and confirmed that it did not appropriately identify the pressure ulcer. On 5/29/24, the facility policy titled, Comprehensive Care Planning was reviewed. The policy read in part, . V. The MDS coordinator is to review the 24-hour report daily for significant changes or changes in resident's ADL [activities of daily living] status. The care planning coordinator will add minor changes in resident's status to the existing care plans on a daily basis . On 5/29/24 at approximately 4:15 p.m., during an end of day meeting, the facility administrator and director of nursing was made aware of the above concern. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information was provided.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 41449 Based on observation, staff interview, clinical record review, and facility documentation review, the facility staff failed to follow professional standards of practice to one resident (Resident #31- R31), during medication observations conducted on one of two nursing units. The findings included: On 5/28/24 at 4:03 p.m., an observation was conducted of resident medication administration being conducted by LPN #1 (licensed practical nurse). LPN #1 prepared medications to administer to R31. The medications included coumadin and potassium chloride 20 meq ER [extended release]. LPN #1 stated that R31 took medications crushed and LPN #1 proceeded to crush the medications. LPN #1 then entered R31's room and administered the medications. Upon LPN #1's returned to the medication cart, an interview was conducted regarding the crushing of medications. LPN #1 stated that she had hesitated and questioned herself regarding if coumadin could be crushed but had proceeded. When asked about the potassium since it was an extended release tab, LPN #1 confirmed that extended-release medications should not be crushed because, if you crush it, they get all of the medication at one time. LPN #1 further acknowledged that she should not have crushed the potassium. On 5/28/24, at approximately 4:30 p.m., a clinical record review was conducted of R31's chart. This review revealed, a physician order for potassium chloride tablet, ER 20 meq tablet that was to be given four times daily. There was also an order dated 4/24/24, that read, May Crush Meds/Open Capsules, combine all medications, and administer as a single bolus. (Refer to DO NOT CRUSH List for exceptions) Put in food/fluids per patients preference and or as needed unless otherwise indicated. On 5/28/24 at approximately 4:40 p.m., LPN #1 showed the surveyor that she had obtained a new order from the physician for a liquid potassium chloride to be administered and the pill had been discontinued. On 5/29/24 at 11:42 a.m., the director of nursing (DON) was made aware of the above observation. The DON stated that crushing medications can affect the efficacy of some medications and provided the survey team with the facility policy regarding medication administration and a document that read, common oral dosage forms that should not be crushed. On the do not crush listing was potassium chloride with the reason noted as extended release. Review of the facility policy titled, General Dose Preparation and Medication Administration was conducted. The policy read in part, . 2.7 Facility staff should crush oral medications only in accordance with pharmacy guidelines as set forth in Resource: Oral Dosage Forms that Should Not Be Crushed and/or facility policy . On 5/29/24 at approximately 4:15 p.m., during an end of day meeting the facility administrator and director of nursing were made aware of the above findings. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/30/24 at approximately 9 a.m., the regional director of clinical services stated that the facility follows Lippincott Nursing Standards of Practice. According to Lippincott's Manual of Nursing Practice, eighth edition, on page 18, box 2-3 read in part, Common legal claims for departure from standards of care . Failure to administer medications properly and in a timely fashion . No further information was provided.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 41449 Based on observation, resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to provide care and services in accordance with the plan of care to promote the healing of a pressure ulcer, for one resident (Resident 46- R46), in a survey sample of 22 residents. The findings included: For R46, the facility staff failed to float the resident's heels while in bed, to promote the healing of a stage III pressure ulcer on the resident's left heel and prevent the development of a new pressure ulcer on the right foot. On 5/28/24 at 12:10 p.m., R46 was observed sitting in his wheelchair, with a bandage to his left foot. When questioned, R46 was questioned a bandage to his left foot, the resident reported he had a sore there and that they had removed the dead skin from it, and that it was not improving like they wanted. On 05/29/24 at 08:51 a.m., R46 was observed in bed, he had a heel up device [devise used to float heels]. Observations revealed that the device was positioned under the resident's knees and his bilateral heels were resting directly on the bed. R46 reported this is how staff always position the heels up device. R46 went on to say, The wound doctor was here yesterday and said it [the wound] didn't look too good. R46 was asked if he moves the device and repositions it and he said No, I can't. I had a stroke and can't move my left side and as you see I don't have a hand on the right . On 5/29/24 at 9 a.m., RN #2 (registered nurse), accompanied the surveyor to R46's room. RN #2 confirmed that R46's heels were lying on the bed and were not being floated. RN #2 repositioned a pillow so that R46's left heel was floating. On 05/29/24 at 10:53 a.m., a clinical record review was conducted, with special attention given to the documentation regarding the wound. On 5/7/24, R46 was seen by a wound specialist, and their note read in part, . Float heels off bed with pillows or offloading device . R46's care plan with a review date of 5/23/24, had an intervention that read, float heels as tolerated . On 5/30/24 at approximately 8:30 a.m., R46 was visited in his room. R46 stated to the surveyor that he had to educate the staff during the night because they put the heels up device under his knees and he told them to pull it down under his lower legs so his heels would not be on the bed. R46's heels were being floated during this observation. The facility policy titled, Pressure Injury Prevention and Treatment Policy was received and reviewed. The policy statement read, Residents admitted with existing pressure injuries will receive necessary treatment and services, consistent with professional standards of practice, to promote healing and prevent infection. New pressure injuries will not develop unless the individual's clinical condition demonstrates that they were unavoidable. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/29/24 at 4:15 p.m., the facility administrator and director of nursing were made aware of the above findings. No further information was provided.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28106 Based on observation, staff interview, and facility document review, the facility staff failed to ensure expired medication was not accessible for distribution in the medication room on unit two. The Findings include: The facility failed to ensure expired multi-dose vial of Tuberculin was not accessible for distribution on the skilled unit (unit 2). On [DATE] at 1:32 PM unit two's medication storage refrigerator was observed with license practical nurse (LPN #2). The refrigerator had one multi-dose vial of tuberculin medication in it's original box. The vial of Tuberculin had been opened and accessed with approximately 1 to 2 doses of the medication remaining in the vial. The vial of Tuberculin had an opened date of [DATE]. LPN #2 reviewed the opened date and verbalized that the Tuberculin should be discarded after 30 days of being opened and would discard the medication at this time. On [DATE] at 4:11 PM the above finding was presented to the administrator and director of nursing (DON). The DON verbalized that the Tuberculin vial should have been discarded. A policy titled, Storage and Expiration Dating of Medications, Biological's documented, [.] If a multi-dose vial of an injectable medication has been opened or accessed [.], the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial. No other information was presented prior to exit conference on [DATE].

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on observation, staff interview and clinical record review, the facility staff failed to provide fortified food items as required in the plan of care for one of twenty-two residents in the survey sample (Resident #26). The findings include: Resident #26 (R26) was admitted to the facility with diagnoses that included vitamin deficiency, hypertension, diabetes, Alzheimer's disease, cerebral infarction with hemiplegia, dysphagia, major depressive disorder, and cognitive communication deficit. The minimum data set (MDS) dated [DATE] assessed R26 with severely impaired cognitive skills. R26's clinical record documented a physician's order dated 10/2/23 for a fortified foods diet, mechanical soft texture with nectar-thick liquids. A physician's order dated 9/23/23 documented, Food Snack one time a day Fortified Pudding on breakfast tray. R26's plan of care (revised 3/14/24) listed the resident had experienced gradual weight loss and was at risk of malnutrition due to dysphagia. Care plan interventions to maintain adequate nutritional status included, Fortified foods with meals .Provide diet per order . On 5/29/24 at 8:01 a.m., R26 was observed eating breakfast in her room. R26's breakfast tray had no fortified pudding as ordered. The resident's meal ticket listed fortified oatmeal in addition to four ounces of fortified pudding. There was no fortified oatmeal on R26's breakfast tray. R26 was observed eating the provided food items on the tray that included pancakes, ground sausage with gravy, cold cereal/milk and a fruit cup. A covered bowl of oatmeal was observed on the sink counter in R26's room. R26 made no verbal response when asked about her food items. On 5/29/24 at 8:10 a.m., the certified nurses' aide (CNA #3) caring for R26 was interviewed about the breakfast. Accompanied by CNA #3, R26's breakfast was observed. CNA #3 stated there was no fortified pudding on the breakfast tray. CNA #3 stated the pudding came from the kitchen and should have been on the tray when served. CNA #3 stated she had removed the bowl of fortified oatmeal and placed it on the sink counter. When asked why a food item would be removed from the tray, CNA #3 stated, I took the oatmeal off the tray. She [R26] doesn't like it. She eats Cheerios instead. On 5/29/24 at 10:57 a.m., the kitchen supervisor (other staff #1) was interviewed about R26's breakfast that had no fortified pudding and the fortified oatmeal removed from the tray. The kitchen supervisor stated the fortified pudding was made in the kitchen and should have been on the tray when served. The kitchen supervisor stated she did not know why the fortified pudding was not on the tray as it was listed on the meal ticket. The kitchen supervisor stated the fortified oatmeal was provided on the tray and she did not know why the oatmeal was removed from the tray. The kitchen supervisor stated she had no reports or knowledge that R26 did not like oatmeal. The kitchen supervisor stated the oatmeal should have been left on the tray and accessible for the resident to eat. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This finding was reviewed with the administrator, director of nursing and regional consultant during a meeting on 5/29/24 at 4:10 p.m.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41449 Based on observation, staff interview, and facility documentation review, the facility staff failed to store and prepare food in accordance with professional standards for food service safety in one of one kitchen. The findings included: 1. The facility staff failed to store foods in a manner to prevent contamination and failed to label and date items in the freezer and refrigerators. On 5/28/24 at 11:10 a.m., an initial tour of the kitchen was conducted with the dietary manger. This observation revealed that in the refrigerators there was a Ziplock bag that contained hard boiled eggs with a watery liquid in the bag. The bag had no dates to indicate when they were opened or to be used by. There was also a stack of approximately 10 slices of cheese that was wrapped in saran wrap and one corner was open to air. Also, there was no labeling to indicate when the cheese had been opened or to be used by. In the freezer there was a bag of breaded fish that was open to air and not secured, nor dated as to when it was opened. The dietary manager stated she knew it had been opened Friday, because that it when they last had fish. The dietary manager tied the bag closed and placed a date on it. On 5/28/24, during the above observations, the dietary manager confirmed all the findings and stated that all items were to be labeled with the date opened and the date to be used by. She also confirmed that everything was to be closed and stored to prevent contamination. On 5/29/24 at 2:08 p.m., during a follow-up visit to the kitchen, it was observed that in the refrigerator, there was another stack of approximately 15-20 slices of cheese that were wrapped in saran wrap but had no date as to when they were opened or to be used by. There were also 4 sandwiches that were on individual plates and wrapped in saran wrap that had no date when they were prepared or to be used by. The dietary manager confirmed the above observations and stated they had just made the sandwiches and they were for the evening meal but agreed there should be labels to indicate this. A review was conducted of the facility policy titled, Storage of Frozen Foods Policy. The policy read in part, . 9. Food stored in the freezer shall be covered, labeled, and dated . The facility policy titled, Storage of Refrigerated Foods Policy, was reviewed. It read in part, . 11. Store all food/leftovers in covered, approved, food grade containers. 12. Refrigerated, TCS foods, prepared and held for more than 24 hours will be marked to indicate the date the food will be consumed or discarded . The CFR [Federal code] read, 3-305.11 Food Storage .D. A date marking system that meets the criteria . (2) Marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the 2017 Food Code published by the U.S. Public Health Service, FDA U.S. Food & Drug Administration chapter 3, section 3-302.15, page 64 stated: Package Integrity. FOOD packages shall be in good condition and protect the integrity of the contents so that the FOOD is not exposed to ADULTERATION or potential contaminants. According to SERV Safe Fourth Edition manual page 7-3 read, When food is stored improperly and not used in a timely manner, quality and safety suffer. Poor storage practices can cause food to spoil quickly with potentially serious results. General Storage Guidelines: Label food. All potentially hazardous, ready-to-eat food prepared onsite that has been held for longer than twenty-four hours must be properly labeled. The label must include the name of the food and the date by which it should be sold, consumed, or discarded. Page 7-4 stated, Discard food that has passed the manufacturer's expiration date. On 5/29/24 at 3:39 p.m., the facility administrator was made aware of the above findings. No additional information was provided. 2. The facility staff failed to maintain adequate levels of sanitizer in the sanitizer buckets used to clean food preparation surfaces. On 5/28/24 at 11:10 a.m., an initial tour of the kitchen was conducted with the dietary manager accompanying the surveyor. Below the food preparation table, there was a red sanitizer bucket with a cleaning rag in it. The dietary manager used chemical test strips to check the sanitizer level of the cleaner within the bucket. The dietary manager stated that she expected it to be maintained at a level of at least 200 ppm (parts per million). Upon checking the solution tested at only 100 ppm. The dietary manager asked the staff member to change out the sanitizer with fresh. On 5/29/24 at 2:08 p.m., during a follow-up visit to the kitchen. The dietary manager again tested the sanitizer bucket under the food prep table that contained a cleaning cloth. Again, it tested at only 100 ppm. Review of the facility policy titled; Sanitizer Bucket Policy was conducted. The policy read in part, 1. The food and nutrition services manager [dietary manager] shall train all food and nutrition service employees regarding the use of sanitizer test strips, acceptable sanitizer concentration, and the required procedure for documenting sanitizer levels for the sanitizer bucket. 2. Sanitizer strength in sanitizing buckets shall be monitored following each meal and recorded prior to use by the food and nutrition staff. The sanitizer solution shall be replaced when it is determined to be too weak . According to the 2017 Food Code published by the U.S. Public Health Service, FDA U.S. Food & Drug Administration chapter 3, section 3-304.14, page 77 stated: cloths in-use for wiping counters and other equipment surfaces shall be: held between uses in a chemical sanitizer solution at a concentration specified under 4-501.114. On 5/29/24 at 3:39 p.m., the facility administrator was made aware of the above findings. No additional information was provided. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495262	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shenandoah Nursing Home	339 Westminister Drive Fishersville, VA 22939

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. The facility staff failed to properly dry dishes to prevent the development of microorganism growth. On 5/29/24 at 2:19 p.m., observations were conducted of the facility staff washing dishes. It was noted that a dietary aide/other staff #3 (OS #3) was observed removing dishes from the dish washer and immediately stacking them, while wet. This was done for the pellet bottoms and tops (the device that the plates sit in to keep them warm and the cover), the trays, and all dishes to include plates, bowls, etc. Following the above observations an interview was conducted with OS #3. OS #3 stated this is how they always handle the dishes and pellets; they remove them from the dishwasher and immediately stack them. On 5/29/24 at approximately 2:30 p.m., the dietary manager and surveyor looked at several of the pellet bottoms that were stacked, and it was noted they were wet and stored upward where the water could not drain, and air could not dry all surfaces. The dietary manager was also shown the plate and bowl rack where dishes were stacked, face up which didn't allow for proper drying. The dietary manager confirmed the observations, and that wet nesting was occurring which could lead to bacteria growth. On 5/29/24 at 3:39 p.m., the facility administrator was made aware of the above findings. The administrator commented the dietary manager had made her aware and she had found a rack to dry the dishes that she was going to order. Review of the facility policy titled, Dish Machine Use Policy read in part, . 11. Allow the dishes to air dry on the dish racks or open shelving. Do not dry with towels . 17. Dishes should not be nested unless they are completely dry . According to the 2017 Food Code published by the U.S. Public Health Service, FDA U.S. Food & Drug Administration chapter 4, section 4-901.11, titled Equipment and Utensils, Air-Drying Required pages 151-152 stated: After cleaning and SANITIZING, EQUIPMENT and UTENSILS: (A) Shall be air-dried or used after adequate draining as specified in the first paragraph of 40 CFR 180.940 Tolerance exemptions for active and inert ingredients for use in antimicrobial formulations (food-contact surface SANITIZING solutions), before contact with FOOD; and (B) May not be cloth dried except that UTENSILS that have been air-dried may be polished with cloths that are maintained clean and dry. No additional information was provided.