| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075064 | A. Building<br>B. Wing | 06/04/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Milford Health Care Center Inc | 195 Platt Street<br>Milford, CT 06460 |

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|---|---|
| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50250<br><br>Based on review of the clinical record, facility policy, and interviews for 1 of 4 residents (Resident #89) reviewed for nutrition, the facility failed to notify the provider of weight loss. The findings include:<br><br>Resident #89's diagnoses included heart failure, hypertension, and generalized muscle weakness.<br><br>The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #89 was cognitively intact, required set up assistance for eating and assistance of 2 staff for bed mobility and transfers.<br><br>The Resident Care Plan in effect from April 1, 2024, through May 30, 2024, identified Resident #89 was at risk for nutritional deficit due to diuretic use. Interventions included monitoring weights, diet, and notifying dietician, family, and physician of significant weight changes.<br><br>A physician's order dated 4/5/24 directed to weigh Resident #89 daily and notify the provider of a weight change of 3 pounds (lbs.) daily or 5 lbs. weekly.<br><br>Review of Resident #89's clinical record identified that on 5/6/24 he/she weighed 377.0 lbs. and on 5/10/2024 he/she weighed 367.8 lbs (a loss of 9.2 lbs.). Review of the nursing and physician progress notes from 5/10/23 through 6/3/24 failed to indicate that the provider had been notified of Resident #89's weight loss, according to the physician order.<br><br>An interview and record review with LPN #1 (Unit Nurse Manager) on 6/3/24 at 12:10 PM failed to identify that the physician was notified when Resident #89 had a weight loss of 9.2 lbs. in 5 days. LPN #1 was unable to explain the omission but identified that if there was a physician order, then the physician should have been notified.<br><br>Interview with Advanced Practice Registered Nurse #1 on 6/3/24 at 1:30 PM identified that he had not been notified when Resident #89's weight changed by 9.2 lbs. in 5 days. He further identified that he would have had the opportunity to decide if Resident #89's diuretic (water pill) should have been adjusted had he been notified.<br><br>(continued on next page) |



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

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of facility policy identified, in part, that each resident will be weighed upon admission, monthly and when indicated. Significant weight changes will have verification of weight measurement for accuracy and documentation purposes. If verification of weight change indicates significant weight change, the resident and/or family representative and interdisciplinary team will be notified, and plan of care will be revised as appropriate. |

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| F 0646<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Notify the appropriate authorities when residents with MD or ID services has a significant change in condition.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50094<br><br>50177<br><br>Based on interviews, review of the clinical record, and facility policy, for 2 of 7 residents (Resident #3 and Resident #26) reviewed for Preadmission Screening and Resident Review (PASARR), the facility failed to notify the state mental health authority promptly after a new psychiatric diagnosis. The findings include:<br><br>1. Resident 3's diagnoses included delusional disorders, psychotic disorder with delusions due to known physiological condition.<br><br>The Annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 had intact cognition and required total dependence with bathing, substantial/maximal assistance with toileting, and upper/lower body dressing.<br><br>The Resident Care Plan dated 6/7/23 identified Resident #3 had behavior problems-refused to get out of bed, and used antidepressant medication related to having a depressed mood. Interventions included to monitor and document side effects and effectiveness every shift, anticipate and meet resident needs, and monitor for target behaviors: yelling out/profane language.<br><br>Clinical record review identified Resident #3 had a diagnosis of delusional disorder on 8/7/23, but failed to identify the state contracted agency was notified to complete a Level II assessment. Further record review of the Medication Administration Record (MAR) identified Resident #3 was prescribed an antipsychotic on 2/28/24.<br><br>A Psychiatric progress note dated 5/15/24 identified Resident #3 was on Aripiprazole (an antipsychotic) for major depressive disorder (MDD).<br><br>Interview with Person #2 on 6/4/24 at 11:57 AM (the lead clinician for the state contracted Level II evaluation agency) identified Resident #3 should have had a Level II PASARR submitted because the resident had a diagnoses of delusional disorders and according to the psychiatric progress note, Resident #3 was receiving an antipsychotic for major depressive disorder. Additionally, the state contracted Level II evaluation agency indicated that even though it was not on the resident diagnoses list, a diagnoses of delusional disorder was obtained on 8/7/23, the resident was prescribed an antipsychotic on 2/28/24 and a Psychiatric progress note dated 5/15/24 that identified major depressive disorder was sufficient enough to report to the state contracted Level II agency.<br><br>Interview with Social Worker #1 on 6/4/24 at 12:37 PM identified that a Level II PASARR was not submitted in a timely manner because they typically do not report delusional disorder and major depressive disorder, and the diagnoses' were not a part of Resident #3 diagnoses list.<br><br>(continued on next page) |

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| F 0646<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | The facility PASARR policy dated 4/2023 directed, in part, that routine clinical record reviews and facility communication would assist the facility to identify residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition after admission to the facility. Additionally, the PASARR policy directed that the facility designee (social worker) would be responsible for making the referral to the appropriate state designated authority when a resident is identified as having an evident or possible mental disorder, intellectual disability, or related condition.<br><br>2. Resident #26's diagnoses included chronic atrial fibrillation, muscle weakness, and acute kidney failure.<br><br>A PASARR Level 1 evaluation dated 6/10/22 identified Resident #26 was approved indefinitely for long term care and did not identify a psychiatric diagnosis (require a Level II screen).<br><br>The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #26 was cognitively intact and was dependent with showers/bathing, toileting hygiene, and chair to bed transfers. Additionally, the MDS identified Resident #26 had little interest or pleasure in doing things, was feeling down, depressed, or hopeless, and felt tired or had little energy for several days.<br><br>A Psychiatric progress note dated 6/6/23 identified Resident #26 had a psychiatric diagnosis of adjustment disorder with mixed anxiety and depressed mood and was taking Sertraline (an antidepressant medication) 75 mg daily.<br><br>A Psychiatric progress note dated 7/3/23 identified Resident #26 had a new diagnosis of major depressive disorder (which replaced the previous diagnosis of adjustment disorder with mixed anxiety and depressed mood) and Sertraline was increased from 75 mg to 100 mg daily.<br><br>A Social Service note dated 9/21/23 identified Resident #26 experienced episodes of depression and was followed by a psychiatric Advanced Practice Registered Nurse (APRN), last being seen in August of 2023.<br><br>The Resident Care Plan (RCP) dated 1/11/24 identified Resident #26 used antidepressant medication related to behavior disturbances. Interventions included to administer antidepressant medication as ordered, to monitor, document, and report adverse reactions from the medication, and to monitor and record the occurrence of target behaviors.<br><br>A PASARR Level 1 screen dated 5/13/24 identified Resident #26 was referred for a Level 2 screen and identified a psychiatric diagnosis of major depression.<br><br>A PASARR Level 2 screen dated 5/17/24 identified Resident #26 was approved without specialized services for long term care and identified a psychiatric diagnosis of major depressive disorder with recommendations of a minimum of yearly comprehensive psychiatric evaluations to clarify the current psychiatric diagnosis and appropriate treatments, and ongoing evaluation of the effectiveness of current psychotropic medications on target symptoms.<br><br>(continued on next page) |

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| F 0646<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Interview with Social Worker #1 (the Director of Social Services) on 6/4/24 at 8:25 AM identified that the state contracted agency was not notified that Resident #111 had a new psychiatric diagnoses until she completed an annual audit on 5/10/24 (although Resident #111 was diagnosed with major depressive disorder on 7/3/23) because she was not made aware of Resident #26's diagnosis of major depressive disorder. Additionally, Social Worker #1 identified that it was the responsibility of the social workers to ensure completion of PASARRs and to notify the state contracted agency when a resident was identified with a new psychiatric diagnosis.<br><br>An additional interview with Social Worker #1 on 6/4/24 at 10:02 AM identified that she did not complete the request for a PASARR Level 2 when Resident #26 was first diagnosed with major depressive disorder on 7/3/23 because the psychiatric APRN did not notify social services of the change in diagnosis. Social Worker #1 identified new diagnoses or changes are not discussed in RCP meetings because the psychiatric APRN does not attend care plan meetings.<br><br>Interview with Social Worker #1 and Social Worker #2 on 6/4/24 at 10:30 AM identified that social services will review the psychiatric progress notes to verify dates that the residents were seen, and that the social workers do not review the notes in depth unless there was a reason for concern. Additionally, Social Worker #1 identified that if she had seen the new diagnosis of major depressive disorder on 7/3/23, she would have immediately requested a PASARR Level 2 be completed. Social Worker #1 identified that a new PASARR Level 1 was completed along with a PASARR Level 2 when there was a new diagnosis but not until 5/17/24 (10 months after Resident #26 received a new psychiatric diagnoses).<br><br>Review of the PASARR policy dated 4/2023 directed, in part, that routine clinical record reviews and facility communication would assist the facility to identify residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition after admission to the facility. Additionally, the PASARR policy directed that the facility designee (social worker) would be responsible for making the referral to the appropriate state designated authority when a resident is identified as having an evident or possible mental disorder, intellectual disability, or related condition. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50250<br><br>Based on review of the clinical record, facility policy, and interviews for 1 of 3 residents (Resident #52) reviewed for Activities of Daily Living (ADL's), the facility failed to maintain proper fingernail hygiene and care. The findings include:<br><br>Resident # 52's diagnoses included cerebrovascular accident (CVA) with left sided paralysis, muscle weakness, difficulty in walking, and repeated falls.<br><br>The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #52 was cognitively impaired and required staff assistance with personal hygiene and substantial staff assistance with bed mobility and transfers.<br><br>The Resident Care Plan dated 3/21/24 identified Resident #52 had an ADL self-care performance deficit CVA with left side deficit. Interventions included assistance with personal and oral hygiene, bed mobility and transfers.<br><br>Physician's order in effect from 5/1/24 through 6/3/24 directed to perform a total body skin assessment every Monday on the day shift and document in the clinical record.<br><br>Observation's on 5/28/24, 5/29/24, 5/30/24 and 6/3/24 identified Resident #52 with excessively long, jagged fingernails with brown debris underneath.<br><br>Review of the Treatment Administration Record and nursing progress notes for March 2024, April 2024 and May 2024 identified that weekly body audits were signed off by nursing staff on 3/29/27, 4/1/27, 4/8/24, 4/15/24, 4/22/24, 4/30/24,5/6/24, 5/13/24, 5/21/24, and 5/27/24, but failed to note Resident #52's long, jagged fingernails.<br><br>Interview and observation with LPN #1 (Unit Nurse Manager) on 6/3/24 at 10:30 AM identified that Resident #52's fingernails were excessively long, possibly infected with fungus and in need of fingernail care. LPN #1 indicated she was previously unaware of the situation. She further identified that nurse aides (NA's) were responsible for fingernail care and reporting of any irregularities to licensed nursing staff.<br><br>Subsequent to surveyor inquiry, Resident #52's fingernails were cleaned and trimmed on 6/3/24 and the Advanced Practice Registered Nurse (APRN) was notified of a possible fungal infection of Resident #52's fingernails.<br><br>Interview and record review with APRN #1 on 6/3/2024 at 1:30 PM identified that the previous APRN had been informed of a possible fungal infection of Resident #52's fingernails in 3/24 and that Vicks Baby Rub External Cream was recommended. Further review of the physician orders identified that there was a physician's order in place for application of Vicks Baby Rub External Cream to be applied to Resident #52's toenails, but nothing for the fingernails.<br><br>Subsequent to surveyor inquiry, APRN #1 indicated that he would place an order for Vicks Baby Rub for Resident #52's fingernails.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Interview with the Assistant Director of Nursing Services (ADNS) on 6/4/24 at 8:52 AM identified that fingernail care was to be done by nursing staff on a weekly basis on shower days and with full body audits and that Resident #52's fingernail issues should have been identified by the licensed staff conducting the skin audit.<br><br>The facility policy for Activities of Daily Living directed in part that staff were to provide assistance with the completion of ADL activities per the person-centered evaluation and care plan. The activities are broken down into eight areas including personal hygiene and grooming. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50095<br><br>Based on interviews and review of the clinical record for 1 of 5 residents reviewed for unnecessary medications, the facility failed to ensure Resident #1's abnormal laboratory results were addressed. The findings include:<br><br>Resident #1's diagnoses included schizoaffective disorder, left-sided weakness, and hypertension.<br><br>The readmission nursing assessment dated [DATE] identified Resident #1 was moderately cognitively impaired, needed supervision for personal hygiene, and needed set up assistance with eating.<br><br>An APRN's order dated 4/19/24 directed staff to complete laboratory work for Resident #1 to obtain a thyroid stimulating hormone (TSH) level.<br><br>laboratory results dated [DATE] identified Resident #1 had a TSH level of 9.487 milliunits per liter (mU/L) (normal range 0.48 - 4.17 mU/L).<br><br>Interview and clinical record review with APRN #1 on 6/3/24 at 1:42 PM identified that although he signed the 4/19/24 laboratory results as reviewed, APRN #1 did not notice Resident #1's abnormal TSH level and failed to address it. APRN #1 subsequently indicated that he would write an order to redraw the TSH level.<br><br>Interview and review of the clinical record with the DNS on 6/4/24 at 10:18 AM failed to identify APRN #1 had written any new orders requesting Resident #1's TSH level be redrawn.<br><br>Subsequent to surveyor interview, the DNS identified she would be contacting APRN #1 for to order a redraw of a TSH level.<br><br>Although requested, a facility policy for addressing abnormal laboratory results was not provided. |

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| F 0730<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Observe each nurse aide's job performance and give regular training.<br><br>50059<br><br>Based on staff interview and review of 1 of 2 Nurse Aide (NA #3) personnel files, the facility failed to complete a yearly performance review. The findings include:<br><br>NA #3's date of hire was 1/20/23.<br><br>On 6/4/24 at 1:30 PM, interview and review of NA #3's employee file identified that NA #3 was currently employed at the facility and failed to identify a yearly performance review had ever been completed (4 months since a performance appraisal was due). Additionally, the DNS identified that NA #3's performance appraisal had been completed but not reviewed or signed by NA #3 because NA #3 currently only works weekends and the DNS had not seen NA #3 to review the performance appraisal.<br><br>A review of NA #3's Employee Punch Card History revealed there were at least two occasions where NA #3 worked a weekend 3:00 PM to 11:00 PM shift. These dates included 3/8/24 and 5/23/24. |

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| F 0755<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50059<br><br>Based on observation, review of facility documentation, review of facility policy, and interviews during a review of the facility's medication storage and reconciliation program in 1 of 2 medication rooms, the facility failed to appropriately store and reconcile a discontinued controlled substance (narcotic). The findings include:<br><br>Resident #62's diagnosis included dementia, depression, psychotic disorder, and anxiety.<br><br>A physician's order dated [DATE] directed to administer Lorazepam concentrate liquid 2 milligrams (mg)/milliliter (ml) ), give 0.25 ml(0.5 mg) by mouth three times daily as needed for anxiety.<br><br>A physician's order dated [DATE] discontinued Resident #62's liquid Lorazepam.<br><br>During an observation and interview of the second floor medication storage room with the Registered Nurse Supervisor (RN #2) on [DATE] at 12:10 PM an open vial of Lorazepam concentrate liquid 2 mg/ml, belonging to Resident #62, was noted in a locked storage box in the locked refrigerator. Review of the medication label for the liquid Lorazepam identified the medication was ordered on [DATE] and received into the facility on [DATE]. RN #2 stated that although she was aware that the vial of Lorazepam was stored in the locked refrigerator, she indicated that the Lorazepam did not have a corresponding Controlled Substance Disposition Record (CSDR) (document identifying the amount of controlled substance was used and how much remained in the container). RN #2 indicated that CSDR are used to ensure that the appropriate amount of medication had been administered, how much medication remained in the container, and was used to count narcotic medications during each change of shift for reconciliation custody purposes. RN #2 stated that only Registered Nurse Supervisors (RNS) possessed keys to the locked medication box and that the keys were passed from RNS to RNS with each change of shift. RN #2 further indicated that unit charge nurses were responsible to count all resident narcotics every shift but was unable to explain why the Lorazepam had not been counted and was unable to explain how the unit charge nurse would count the Lorazepam as only the RN Supervisors had keys to access the medication.<br><br>An interview on [DATE] at 12:15 PM with the second floor unit charge nurse, LPN #2 identified that he had worked at the facility for about 1.5 years, and he had no knowledge that liquid Lorazepam had been stored in a locked container in the refrigerator. LPN #2 indicated that RN #2 (the RNS) was the only nurse on the second floor with keys to the locked med storage box where the Lorazepam had been stored. Further LPN #2 indicated that he had never had a key to access the locked container and he did not have a CSDR in his narcotic book which would have indicated that the Lorazepam needed to be counted during shift change.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | An interview with the Director of Nurses (DNS) on [DATE] at 12:33 PM indicated that she had no knowledge of the Lorazepam concentrate liquid stored in the locked medication box on the second floor. Review of Resident #62's CSDR sheet with the DNS identified the Lorazepam had arrived at the facility on [DATE]. The CSDR identified that the last dose of medication that was administered to Resident #62 was on [DATE], the medication was subsequently discontinued on [DATE], but another entry had been noted on [DATE] that showed the medication had been administered on that date. Review of Resident #62's Medication Administration Record failed to reflect that Resident #62 had received the dose of Lorazepam administered on [DATE]. The DNS was unable to explain, why the Lorazepam remained on the unit without a CSDR , why the Lorazepam had not been counted for the past approximately 2.5 years to prevent diversion, why the Lorazepam had not been returned to the DNS office for appropriate destruction following discontinuance, or why the medication had been recorded as dispensed on [DATE] after being discontinued with no record indicating that Resident #62 had received the [DATE] dose signed out. The DNS indicated that it was ultimately her responsibility to ensure medications were disposed of properly per facility policy, but this event had occurred prior to her employment with the facility and she was unaware of the presence of the medication in the building. Subsequent to surveyor inquiry, the Lorazepam was returned to the DNS off for appropriate disposal.<br><br>Review of the policy for Controlled Substance Destruction, directs any unused or expired controlled substances will be destroyed in a manner consistent with Connecticut Department of Consumer Protection regulations. The policy also stated that Nurses shall document and destroy unused and expired controlled substances in accordance with the following statute Connecticut DCP regulation 21a-262(g). |

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|---|---|
| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50179<br><br>Based on the tour of the Dietary Department, staff interview, facility documentation and facility policy, the facility failed to ensure the Dietary Department consistently labeled opened dry food with the date opened and expiration dated and failed to ensure canned goods identified an expiration date. The findings included:<br><br>Tour of the Dietary Department on 5/28/24 at 10:46 AM with the Food Service Director identified the following:<br><br>a. Large plastic bulk bins containing flour which was approximately 1/4 full, rice which was approximately 1/4 full, sugar which was approximately 3/4 full and oatmeal approximately 1/2 full without the benefit of identifying the date the contents were poured into the bin, and lacking an expiration date.<br><br>b. An opened 34 ounce (oz) plastic bag, approximately 3/4 full, which contained a round cereal without the benefit of identifying the date the contents were opened and lacking an expiration date.<br><br>c. An opened 34 oz plastic bag, approximately 1/4 full, which contained [NAME] bran cereal, without the benefit of identifying the date the contents were opened and lacking an expiration date.<br><br>d. An opened 34 oz plastic bag, approximately 1/4 full, which contained corn cereal without the benefit of identifying the date the contents were opened and lacking an expiration date.<br><br>e. An opened 1/2 bag full of dry pasta without the benefit of identifying the date the contents were opened and lacking an expiration date.<br><br>f. An opened loaf of bread, approximately 1/3 full without the benefit of identifying the date the contents were opened and lacking an expiration date.<br><br>g. Three 6 pound (lb) 10 oz cans of creamed corn, nine 6 lb and 11 oz cans of pizza sauce, five 6 lb and 12 oz cans of pinto beans, nine 6 lb and 9 oz cans of diced peaches, eleven 6 lb and 9 oz cans of diced pears, fifteen 10 lb and 6 oz cans of spaghetti sauce and five 55 oz cans of sliced olives identified an expiration date in code, the code was unable to be deciphered.<br><br>Interview and observation with Food Service Director on 5/28/24 at 10:46 AM indicated that Dietary staff were responsible for dating food products after opening them.<br><br>Interview with the Food Service Director on 5/30/24 at 11:45 AM noted that he was unsure of the expiration dates on the canned items because the cans contained a code and not an expiration date. The Food Service Director stated he thought the cans were good for 1 to 2 years.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075064 | A. Building<br>B. Wing | 06/04/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Milford Health Care Center Inc | 195 Platt Street<br>Milford, CT 06460 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Although the Food Service Director provided a document USDA canned food shelf-life healthcare guidelines that identified low acid canned food will keep for 2 to 5 years if unopened and high acid canned foods for best quality 12 to 18 months, he was unable to provide documentation as to the expiration dates.<br><br>The facility policy for Labeling and rotating food supply: food products that are opened and not completely used: transferred from its original package to another storage container; or prepared at the facility and stored should be labeled as to its contents and used by dates. Food removed from its original container must be labeled with the common name of the food.<br><br>Rotate food products to ensure the oldest inventory is used first commonly known as first in first out (FIFO). A product used by date or delivery date is marked on the product.<br><br>Employees stock shelves with earliest used by dates or delivery dates in front of products with later dates. Additionally, before shelving new stock, mark all containers currently on the shelf with a FIFO sticker or a color coded sticker. |