STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	745050	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Kerrville	1555 Bandera Hwy Kerrville, TX 78028

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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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to manage the personal funds of the residents deposited with the facility for 1 (Resident #3) of 5 residents reviewed for access to personal funds. The facility failed to provide Resident with personal funds upon request for at least 2 months. This deficient practice could place residents at risk for not having money to purchase personal items to meet their needs. The findings were:Review of Resident #3's face sheet, dated 4/24/26, revealed he was admitted to the facility on [DATE] with diagnoses including unspecified Dementia, unspecified severity with other behavioral disturbance and bipolar disorder unspecified. Review of Resident #3's quarterly MDS assessment, dated 3/11/26, revealed Resident #3's BIMS score was 15 reflected he did not have cognitive impairment. Review of Resident #3's Care Plan, dated 9/30/26, revealed Resident #3 was at risk of low self-esteem and interventions included encourage Resident/Representative participation in decision process regarding treatment program. Review of Resident #3's Resident Fund Management Service, revealed the account was opened on 9/10/25 and the current balance was $3965.39 as of 4/21/26. Further review revealed $6320 was deposited into Resident #3's trust fund account on 1/27/26. He was provided with $150. on 2/24/26. Interview on 4/23/26 at 3:40 PM with Resident #3 revealed he was in his room sitting in a chair next to the bed. Resident #3 presented as being alert and oriented to person, place and time. He reported he was admitted to the facility during September 2025 and during October 2026 he requested $600 dollars from his trust fund to buy clothes and silk pillowcases. Resident #3 stated some of his clothes were damaged while being laundered and he liked the silk pillowcases because they kept him cool and from sweating. Resident #3 stated he did not understand why he had not received any of his monies because the trust fund balance from his previous placement had been deposited into his account at the nursing facility. Resident #3 stated he talked with the previous BOM, but since then she left and another person took over the position. He stated he talked with the new BOM and requested monies since at least October 2025 and stated he received 150 dollars but not the amount he requested. Again, Resident #3 expressed frustration and commented staff did not seem to care. Interview on 4/24/26 at 2:10 PM, the BOM revealed Resident #3 request $350 early January or February 2026. He stated he assumed his position as BOM not long ago and was still learning his position. The BOM stated he talked with Resident #3 several times about his request for funds but stated providing funds to him was delayed because there had been high staff turnover including the ADM. The previous ADM was the person who cashed their petty checks which was where he withdrew monies for residents upon their request. He stated the current ADM started his position about 2 weeks ago and at that time he discussed Resident #3's request to withdraw $300 with the ADM and his regional support. The BOM stated he was provided with $300 in petty cash every month from which he disbursed monies to residents from their trust fund upon their request. He stated Resident #3 received $75 every month from MCD and he requested a lump sum accumulated amount since his admission on [DATE]. The BOM stated Resident #3's family member assisted Resident #3 in withdrawing Resident #3's trust fund balance from the previous facility where Resident #3 resided. The balance of the trust fund balance was deposited into Resident #3's account at the facility. The BOM stated he provided (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #3 with $150 on 2/23/26 but Resident #3 had been requesting the entire balance he was owed in a lump sum so he could buy clothes. The BOM stated at this point Resident #3 was owed $375. He stated corporate office provided him with $300 monthly in petty cash. He stated he told Resident #3 that he would not be able to provide him with the entire amount because of the petty cash limitations, but Resident #3 insisted on the entire amount. The BOM stated he spoke with his regional support and was advised he would have to split the amount into 2 withdrawals. The BOM stated the ADM told him a couple of weeks ago he was waiting for permission to cash the petty cash checks provided from their corporate office. He stated the ADM had not said anything to him since that time. The BOM stated he understood Resident #3 had a right to have access to his funds and Resident #3 expressed his frustration every time they met. Interview on 4/24/26 at 3L46 PM, the ADM revealed the BOM talked with him on Tuesday or Wednesday of this week (4/21/26 or 4/22/26) about Resident #3's request to withdraw monies from his account. The ADM stated Resident #3 had a right to access to his personal funds and was waiting for approval from corporate office to cash the petty cash checks. The ADM stated he had not talked with Resident #3 but according to the BOM Resident #3 requested funds since the end of February. He stated he understood Resident #3 was frustrated because he had been waiting for monies. The ADM stated not providing residents with access to their funds could lead to feelings of helplessness. Review of facility policy, Resident Rights, dated February 2021, read in relevant part,1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's rights to:e. self-determination; h. be supported by the facility in exercising his or her rights; r. manage his or her personal funds, or have the facility manage his or her funds (if he or she wishes).

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to have evidence all allegations of abuse, neglect or mistreatment were thoroughly investigated and documented for 1 of 5 residents (Resident #2) reviewed for abuse. The facility failed to have evidence that a thorough investigation was conducted following the allegation regarding staff blew cigarette smoke in front of Resident #2. These failures could place residents at risk for abuse and neglect by not investigating allegations of abuse, neglect, exploitation, or mistreatment. The findings were: Record review of Resident # 2's face sheet, dated 04/24/2026, revealed the resident was an [AGE] year-old female and admitted to the facility on [DATE] with diagnoses of age-related osteoporosis with current pathological fracture (fracture due to declining bone mass and strength), Alzheimer's disease (a neurodegenerative disease that destroys cells in your brain, causing loss of some brain functions, including memory and language), and Anxiety (a feeling of worry, nervousness, or unease, typically about an imminent event or something with an uncertain outcome). Further record review of the face sheet revealed the resident was discharged to the home on [DATE]. Record review of Resident #2's admission MDS assessment, dated 02/14/2026, revealed the resident's BIMS score was 5 out of 15, which indicated severe cognitive impairment. The admission MDS assessment further revealed Resident #2 required Partial/moderate assistance (Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) to chair to bed and toilet transfer. Record review of Resident #2's Incident Investigation Worksheet, received 02/19/2026, revealed the facility administrator reported to Texas HHSC regarding It was alleged that staff members blew smoke in the direction of resident and family out in the designated smoking area while family visiting with loved one. Record review of the facility's Provider Investigation Report 3613-A's revealed that Resident #2's allegation there was no Provider Investigation Report 3613-A in the facility records Record review of Texas Unified Licensure Information Portal (TULIP) accessed (date) indicated there was no report of Resident #2's allegation. Record review of Resident #2's nursing progress note by LVN-D, dated 02/19/2026, revealed that Resident #2 and family member denied staff blew cigarette smoke in front of Resident #2 on 02/19/2026 at the smoking area. Interview on 04/23/2026 at 4:45 p.m. with LVN-D said she did not work at the facility anymore and could not recall who CNAs smoked cigarettes, but she performed interviews with Resident #2 and family, and they denied CNAs blew cigarette smoke in front of the resident. Interview on 04/23/2026 at 4:15 p.m., the Administrator said he did not work on 02/19/2026 because he started working on March 2026 at the facility, so he could not know what happened to Resident #2 on 02/19/2026. The Administrator said he searched all records, computers that previous administrator used, and files but could not find the facility provider investigation report 3613-A regarding Resident #2's allegation. Further interview with the Administrator said there was also no evidence that the previous administrator submitted Provider Investigation Report 3613-A to Texas HHSC within 5 days, and he said the facility administrator should have conducted thorough investigation regarding Resident #2's allegation and submitted provider investigation report 3613-A to Texas HHSC within 5 days to prevent possible abuse or neglect. Record review of the facility policy, titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised 09/2022, revealed . 7. All allegations are thoroughly investigated. The administrator initiates investigations. Follow-Up Report. 1. Within five (5) days of the incident, the administrator will provide a follow-up investigation report. 2. The follow-up investigation report will provide sufficient information to describe the results of the investigation, and indicate any corrective actions taken if the allegation was verified.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good grooming, and personal hygiene for 1 of 1 Resident (Resident #4) reviewed for showers. The facility failed to ensure Resident #4 received a shower on his scheduled shower days. This deficient practice could place residents at risk of poor hygiene and poor self-esteem. The findings were:Review of Resident #4's face sheet, dated 4/24/26, revealed he was admitted to the facility on [DATE] with diagnoses including personal history of traumatic brain injury, Parkinson's and unspecified lack of coordination. Review of Resident #4's quarterly MDS assessment, dated 4/13/26, revealed his BIMS was 15 reflected he did not have cognitive impairment. Further review revealed Resident #4 was dependent on 1 to 2 staff for all ADL's except eating. Review of Resident #4's Care Plan, dated 2/13/26 read: Resident #4 was at Risk for Self-Care Deficit: Bathing, Dressing, Feeding and some of the interventions included Evaluate Resident's ability to perform ADLs; Provide assistance with ADLs as needed. Review of Resident #4's plan of care for showers revealed he received a shower on 3/26/26, 3/31/26 and on 4/18/26. Observation and interview on 4/24/26 at 3:50 PM revealed Resident #4 was lying in bed. Further observation revealed Resident #4 was able to speak, but could not understand him. He took out his phone and slowly communicated via phone. Noted Resident #4 upper range of motion was extremely limited. He was able to move his hands, but his range of motion for bilateral upper extremities was restricted. Resident #4 stated staff took a long time, sometimes up to an hour to answer his call light. He stated he had not received a shower since 4/18/26 and he felt dirty. Resident #4 stated he wanted a shower and felt helpless. Interview on 4/2426 at 3:54 pm, CNA D revealed Resident #4 was totally dependent for all ADL's including showers. She stated Resident #4 received showers on Tuesday's, Thursday's and Saturdays on the night shift between 10:00 pm to 6 am. She stated he often complained that he did not receive shower so staff on the 2:00 pm to 10 pm would attempt to fit him into their shower schedule. CNA D stated it was important for Resident #4 to received regular showers, otherwise, like Resident #4, resident would feel bad about not being showered. CNA D reviewed Resident #4's showers plan of care for March and April 2026 and stated it looked like Resident #4 received a shower on 3/26/26, 3/31/26 and on 4/18/26. CNA D stated she could not imagine how Resident #4 would feel only having received 3 showers in almost 30 days. CNA D stated if it was her, she would feel awful, disgusted and would believe staff did not care about her needs. CNA D stated it was unacceptable that Resident #4 had only received 3 showers. Interview on 4/24/26 at 4:15 pm, LVN E revealed she was not aware that Resident #4 was not receiving scheduled showers. She stated most recently she understood Resident #4 shower schedule changed and he was to receive showers on the night shift by only male CNA's because of his inappropriate behaviors towards female staff. Interview on 4/24/26 at 6:20 PM, charge nurse LVN F revealed the facility usually only had 1 CNA on the night shift to work the hall Resident #4 resided in and there was usually only 1 nurse scheduled to work Resident #4's hall and one other hall. He stated it was difficult to ensure all tasks were completed including resident showers with limited staff. He stated he was not aware that Resident #4 was not receiving scheduled showers and as a night nurse he tried to ensure CNA's completed their tasks but it had been a while since he was able to review the CNA's electronic plan of care to ensure they were completing showers. LVN F was apologetic but commented, I can only do so much. Interview on 4/24/26 at 6:35 PM, the DON revealed she assumed her position 2 days prior and did not know the resident's shower schedules. She stated for a resident who wanted to be shower and did not receive a shower could lead to the resident feeling bad and contribute to feelings of low self-esteem. The DON stated for this reason it was important that staff provided scheduled showers Review of facility policy, Activities of Daily Living Supporting, dated February 2025 read in relevant part Resident who are unable to carry out activities of daily living independently will receive (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the services necessary to maintain good nutrition, grooming and personal and oral hygiene.2. Appropriate care and services will be provided for residents who are unable to carry out ADL's independently, with the consent of the resident and in accordance with the plan of care including appropriate support and assistance with:a. hygiene (bathing, dressing, grooming, and oral care).

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, interviews, and record reviews, the facility failed to ensure the residents had the right to a safe, clean, comfortable, and homelike environment including but not limited to receiving treatment and support for daily living safely for 1 of 4 hallways (400-hall) reviewed for safe environment. A lunch tray that had leftover food without a cover was on the furniture unattended at the 400-hallway. This failure could place residents at risk for foodborne illness or choking if some confused residents might eat the leftover food on the lunch tray. The findings include: Observation on 04/21/2026 at 3:40 p.m. revealed one lunch tray was on the furniture at the middle of 400-hallway unattended, the lunch tray had leftover food that some resident in 400-hall ate and left, and the main lunch dish was very open without a cover. Further observation revealed nobody was on the 400-hallway, and the leftover food was cornbread, squash, salad, and chocolate chip cookies. Further observation revealed no residents wandered on the 400-hallway. Interview on 04/21/2026 at 3:41 p.m., the ADON stated one lunch tray that had leftover food some resident in 400-hall ate and left was on the furniture unattended at the 400-hallway, and the lunch dish was very open without a cover. The ADON said open lunch tray without a cover unattended was not good because some confused residents who had different food textures might eat the leftover food on the tray and might have choking. The ADON said staff should have returned all lunch trays to the kitchen, instead of putting the tray on the furniture on the 400-hallway. Interview on 04/21/2026 at 3:45 p.m. with DON said it was not acceptable that staff put lunch trays with leftover food on the furniture at the 400-hallway unattended because some confused residents might eat the leftover food and might have infection or choking, and staff should have returned all lunch trays to the kitchen immediately whenever residents completed eating their lunch in their rooms and said the facility did not have a policy related to meal trays, but the facility should maintain safe environment for residents.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 8 residents (Resident #1) reviewed for pharmacy services. The facility failed to ensure Resident #1's diazepam for anxiety was administered on 12/13/25, 12/14/25, 12/15/25. 12/16/25, 12/19/25, 12/20/25, and 12/21/25 (total 7 days and 11 doses) because the medication was not available, and the nurses did not contact the pharmacy, physician, or DON. These failures could place residents at risk of inaccurate drug administration and not having appropriate therapeutic effects. The findings included: Record review of Resident #1's face sheet, dated 04/22/2026, revealed the resident was an [AGE] year-old female, originally admitted on [DATE], and re-admitted to the facility on [DATE] with diagnosis of acute on chronic diastolic heart failure (a condition in which heart's main pumping chamber - left ventricle - becomes stiff and unable to fill properly), Chronic obstructive pulmonary disease (common lung disease causing restricted airflow and breathing problems), and anxiety disorder (symptoms of intense anxiety or panic that are directly by a physical health problem). Further record review of the resident's face sheet revealed the resident was discharged to the assisted living facility on 02/26/2026. Record review of Resident #1's admission MDS, dated [DATE], revealed the resident's BIMS score was 15 out of 15, which indicated the resident's cognitive function was intact and receiving antianxiety every day as ordered. Record review of Resident #1's comprehensive care plan, revised 12/15/2025, revealed I [Resident #1] use psychotropic medications (diazePAM). For intervention - Administer medications per order and Discuss with a physician and family the continued need for use of medication. Review behaviors/interventions, alternative therapies, and effectiveness. Record review of Resident #1's physician order, dated 12/12/2025, revealed the resident had the order of diazePAM Oral Tablet 2 milligram (Diazepam) Give 1 tablet by mouth two times a day related to ANXIETY DISORDER HOLD FOR SEDATION OR EXCESSIVE SLEEPINESS -Start Date- 12/12/2025. Further record review of the physician order revealed the physician changed the to diazepam 5 mg 1/2 tablet two times a day on 12/16/2025. Record review of Resident #1's medication administration record, dated from 12/01/2025 to 12/31/2025, revealed Resident #1's diazepam was scheduled 7:30 AM and 7:30 PM. Further record review of the medication administration record revealed the resident did not receive the medication on 12/13/25, 12/14/25, 12/15/25. 12/16/25, 12/19/25, 12/20/25, and 12/21/25 (total 7 days and 11 doses). Record review of Resident #1's Orders-Administration Notes, dated 12/13/25, 12/14/25, 12/15/25. 12/16/25, 12/19/25, 12/20/25, and 12/21/25, revealed Resident #1's diazepam was unavailable. Interview on 04/22/2026 at 4:10 PM, MA-A said she worked 12/13/25 and 12/14/25, but she did not recall if or not she notified a charge nurse regarding Resident #1's diazepam was not available. MA-A said if she did not have a medication, she reported it to the charge nurse all the time, and the charge nurse might take the medication from the emergency kit or contact pharmacy, physician, or DON if the nurse could not take the med from the emergency kit. Interview on 04/22/2026 at 4:30 PM, LVN-B said she worked 12/13/25 and 12/14/25, but she did not recall if or not she contacted pharmacy, physician, or DON regarding Resident #1's diazepam was not available. LVN-B said if she did not have medication, she tried to take the medication from the emergency kit or contact pharmacy, physician, or DON if the nurse could not take the medication from the emergency kit. Further interview with the LVN-B said she did not work at the facility anymore since December 2025. Interview on 04/22/2026 at 5:15 PM, the DON said she did not work on dates of 12/13/25, 12/14/25, 12/15/25. 12/16/25, 12/19/25, 12/20/25, and 12/21/25 because she started working at the facility in April 2026. Further interview with the DON stated she did not know if or not the facility nurse tried to get Resident #1's diazepam from the emergency kit, contact physician, (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pharmacy, or DON who worked on December 2025, but because of no nursing documentations, nurses might not try to take the med from emergency kit, contact physician, pharmacy, or even DON or facility medical director. The DON said when some medications were unavailable, nurses should contact physicians, instead of only documenting Meds Unavailable. The DON said if the resident did not receive the medication, the resident might have anxiety, but per the resident's medical record, the resident did not have a negative outcome regarding anxiety and discharged to an assisted living facility. Record review of the facility policy, titled Administering Medications, revised 04/2019, revealed . 8. If a dosage is believed to be inappropriate or excessive for a resident or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the mediation will contact the prescriber, the resident's attending physician or the facility's medical director to discuss the concerns.

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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. Based on observations, interviews, and record review, the facility failed to ensure all drugs and biologicals were labeled in accordance with currently accepted professional principles and stored in locked compartments for 1 (400-hall nursing cart) of 3 medication carts reviewed for medication storage. The facility failed to ensure the 400-hall nursing cart was not left unlocked and unattended on 04/23/2026. These failures could place residents at risk of ingesting medications not prescribed for them or drug diversion. The findings were:Observation on 04/23/2026 at 9:12 a.m., revealed the 400-hall nursing cart was unlocked and unattended. Interview on 04/23/2026 at 9:18 a.m., LVN-C stated the 400-hall nursing cart was unlocked and unattended. LVN C said she forgot to lock the cart when she left to see some residents, she said it was her mistake. The nurse stated nursing carts should be locked at all times to prevent someone from taking any medication. Interview on 04/23/2026 at 5:15 p.m., the DON said facility nurses should always lock the medication carts to prevent someone from taking the medications. Record review of the facility policy, titled Administering Medications, revised 04/2019, revealed . 19. During administering of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. It may be kept in the doorway of the resident's room, with open drawers facing inward and all other sides closed. No medications are kept top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by.

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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 - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for storage, preparation and sanitation. 1. The facility failed to discard hamburger burns, with a best used by date of 04/22/2026, from the kitchen cooking table on 04/23/2026. 2. The facility failed to label and date Jello stored in the refrigerator inside the facility kitchen. These failures could place residents who received meals and/or snacks from the kitchen at risk for food-borne illnesses. Findings included: 1. Observation of the kitchen on 04/23/2026 at 10:05 a.m., revealed there was one packet of hamburger burns (total 15 burns inside the packet) on the cooking table, the label on the packet said, Best used by 04/22/2026. 2. Observation on 04/23/2026 at 10:10 a.m., revealed a refrigerator labeled as C-1 Refrigerator had a tray with Jello inside, the Jello was not labeled and dated. Interview on 04/23/2026 at 10:13 a.m., the kitchen manager stated the hamburger buns expired on 04/22/2026, so the facility kitchen staff should have discarded it to prevent possible use and food-borne illness. Further interview with the kitchen manager said the facility staff should have labeled and dated the Jello located inside C-1 refrigerator per the facility policy and to prevent possible food-borne illness, and it was kitchen manager's responsibility to discard expired food. Record review of the facility policy, titled Food Receiving and Storage, revised 11/2022, revealed 1. All foods stored in the refrigerator or freezer are covered, labeled and dated (used by date). 7. Refrigerator foods are labeled, dated and monitored so they are used by their use-by date, frozen, or discarded.