STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345487	A. BUILDING _____ B. WING _____	C 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY POINT BAY NURSING AND REHABILITATION CENTER	110 MCCOTTER BOULEVARD HAVELOCK, NC 28532

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 07/08/24 through 07/11/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #BWFD11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 07/08/24 through 07/11/24. Event ID#: BWFD11. The following intakes were investigated: NC00215908, NC00213007, NC00212877, NC00210221, NC00210008, NC00207746 and NC00207600. 26 of the 26 complaint allegations did not result in deficiency.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the	F 578		8/2/24

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

Electronically Signed | 07/26/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345487	A. BUILDING _____ B. WING _____	C 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY POINT BAY NURSING AND REHABILITATION CENTER	110 MCCOTTER BOULEVARD HAVELOCK, NC 28532

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 1 resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on records review, and staff interviews, the facility failed to ensure advance directives were accurate throughout the medical record (Resident #5) and that a copy of the resident's advanced directive was in the medical record (Resident #31) for 2 of 2 residents reviewed for advance directives. 1. Resident #5 was admitted to the facility on 10/5/19 and readmitted on 5/24/24. Resident #5's physical chart was observed to contain a completed Medical Orders for Scope of Treatment (MOST) (advance directive) document dated 3/23/23 signed by the resident's representative and the attending physician that	F 578	F 578 Request/Refuse/Discontinue Treatment; Formulate Adv Directive On 7/8/24, the Social Worker clarified the advance directive wishes for Resident #5 to be a full code and to receive Cardiopulmonary Resuscitation (CPR). On 7/8/34, the social worker updated the physician order for CPR and full code status in the electronic medical record and physical chart to include the advance directives for Resident #5. On 7/8/2024, the social worker clarified	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345487	A. BUILDING _____ B. WING _____	C 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY POINT BAY NURSING AND REHABILITATION CENTER	110 MCCOTTER BOULEVARD HAVELOCK, NC 28532

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 2 indicated the resident desired for cardiopulmonary resuscitation (CPR) to be performed if she stopped breathing and her heart stopped beating. The physical chart was further observed to contain a Do Not Resuscitate (DNR) document that indicated that CPR would not be performed if Resident #5 stopped breathing and her heart stopped beating. The DNR was dated 5/24/24 and contained an illegible signature on the line specified for a physician signature. A review of Resident #5's electronic medical record (EMR) and an order dated 5/24/24 revealed Resident's #5's code status was a full code. A review of the quarterly Minimum Data Set (MDS) dated 5/29/24 revealed that Resident #5 was severely cognitively impaired. A review of Resident #5's care plan dated 6/18/24 revealed that she had an advance directive of full code in place with a revision date of 6/4/24. The goal was that the advance directive would be honored by staff. In an interview with Nurse #1 on 7/8/24 at 2:40 pm she stated that both the MOST form with the full code (perform CPR) directive and the Do Not Resuscitate (DNR) form should not both be on the physical chart at the same time because they contradicted one another. She indicated that she thought the DNR would be correct form because it had the more current date of 5/24/24. She then checked the electronic medical record for Resident #5 and stated that Resident #5 was listed as a full code in the electronic medical record and clarified that Resident #5 was a full code and not a DNR. She went on to explain that	F 578	the advance directive wishes for Resident #31 to be a full code and to receive CPR. On 7/8/24, the social worker updated the physician order for CPR and full code status in the electronic medical record and physical chart to include the advance directives for Resident #31. On 7/8/24, the social worker initiated an audit of all advance directives to ensure the accuracy of orders and desired code status were reflected in both the physical chart and electronic medical record. The social worker and/or the Director of Nursing (DON) will address all concerns identified in the audit to include notification of the physician of desired advance directive/code status, updating the physical chart and electronic record, and updating the care plan to reflect resident desired advance directive/code status when indicated. The audit will be completed by 8/2/24. On 7/8/2024, the Facility Consultant completed an in-service with the Administrator, Social Worker, Admission Director, the Director of Nursing (DON), and Staff Development Coordinator (SDC) regarding Advance Directives with emphasis on ensuring the nurse and social worker are to be reviewing advance directives with the resident and/or Resident Representative (RR) upon admission and/or re-admission, notifying the physician of desired advance directive/code status, obtaining an order for code status, updating the electronic	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345487	A. BUILDING _____ B. WING _____	C 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY POINT BAY NURSING AND REHABILITATION CENTER	110 MCCOTTER BOULEVARD HAVELOCK, NC 28532

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 3 when Resident #5 returned from the hospital on 5/24/24 that the DNR had been generated by the hospital because they automatically made everyone a DNR and that when she re-admitted to the facility that the DNR should not have been placed in the physical chart. She further stated the DNR on the physical medical record had been signed by a hospital doctor and not by the facility doctor, and the facility did not honor a hospital DNR. She confirmed Resident #5 was a full code not a DNR. She was observed to remove the DNR document from the physical chart. In an interview with Resident #5 on 07/11/24 at 11:28 am she indicated that she was a full code and desired CPR to be performed should she become without a pulse, or her breathing stopped. In an interview with the Social Worker on 7/9/24 at 1:31 pm she stated she met with residents or their representatives within 24 hours after they were admitted, and they filled out MOST (advance directive) form. She stated that she did not meet with Resident #5 or her representative when she was readmitted on 5/24/24 because she was not employed by the facility at that time. She further indicated that if a resident were re-admitted from the hospital that all documents were given to the admitting nurse who would have determined if the code status were accurate. She stated that the facility did not honor DNRs from the hospital and that the form should not have been in Resident #5's physical chart. During an interview with the DON on 7/10/24 at 12:26 pm she stated that Resident #5 should not have had a DNR and Full Code status on the physical chart at the same time. She further	F 578	record and physical chart, and updating the care plan to reflect resident desired advance directive/code status. All newly hired administrators, social workers, admission directors, Directors of Nursing, and SDC nurses will receive the in-service regarding Advance Directives during orientation. On 7/8/24, the SDC Nurse initiated an in-service with all nurses regarding Advance Directives with emphasis on reviewing advance directives with the resident and/or Resident Representative upon admission and/or re-admission, notification of the physician of desired advance directive/code status, obtaining an order for code status, updating the electronic record and physical chart, and the care plan was updated to reflect resident desired advance directive/code status. The in-service will be completed by 8/2/24. After 8/2/24, any nurse who has not received the in-service will receive the in-service prior to the next scheduled work shift. All newly hired nurses will receive the in-service regarding Advance Directives during orientation. The Medical Records Director, Minimum Data Set Nurse, Staff Facilitator and/or Quality assurance nurse will review all admissions during Interdisciplinary Team Meeting (IDT) 4 times a week x 4 weeks then monthly x 1 month, utilizing the Advance Directive Audit Tool. This audit will be completed to ensure that the Social Worker, Admission Director, and/or assigned nurse reviewed the advance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345487	A. BUILDING _____ B. WING _____	C 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY POINT BAY NURSING AND REHABILITATION CENTER	110 MCCOTTER BOULEVARD HAVELOCK, NC 28532

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 4 stated that the DNR form should not have been placed on the physical chart. In a follow-up interview with Nurse #1 on 7/11/24 at 9:09 am she stated that when Resident #5 had been readmitted from the hospital in May of 2024 that the admitting nurse should have placed all medical records that were sent with Resident #5 in a box for the Medical Records department and they would have reviewed and scanned the records and placed them in the EMR, but that did not happen for Resident #5 when she returned from the hospital on 5/24/24. She further indicated that the MOST document was already on the physical chart when Resident #5 was re-admitted and that the DNR had been added to the physical chart in error. She stated that she had been the admitting nurse for Resident #5, and she may have placed the DNR on the physical chart in error. During an interview with the Administrator on 7/10/24 at 8:37 am she stated the DNR document should not have been on Resident #5's chart if she was a full code. She stated the documents contradicted one another. 2. Resident #31 was admitted to the facility on 3/28/23. A review of the quarterly Minimum Data Set (MDS) dated 5/10/24 revealed that Resident #31 was severely cognitively impaired. A review of Resident #31's care plan dated 6/11/24 revealed that he had an advance directive of full code in place with a start date of 4/28/23. A review of Resident #31's electronic medical	F 578	directive/code status with the resident and/or resident representative upon admission/re-admission, the physician was notified of desired advance directive/code status, an order was placed in the electronic record and in the physical chart, and care plan was updated to reflect resident desired advance directive/code status. Any concerns identified during the review will be immediately addressed by the Medical Records Director, Minimum Data Set Nurse, Staff Facilitator and/or Quality assurance nurse to include providing additional retraining as appropriate. The Director of Nursing (DON) will review the Advance Directive Audit Tool 4 times a week x 4 weeks, then monthly x 1 month to ensure all concerns are addressed. The Quality Assurance Nurse or Nurse Manager will forward the results of the Advance Directive Audit Tool to the Quality Assurance and Performance Improvement (QAPI) Committee monthly x 2 months. The QAPI Committee will meet monthly x 2 months and review the Advance Directive Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345487	A. BUILDING _____ B. WING _____	C 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY POINT BAY NURSING AND REHABILITATION CENTER	110 MCCOTTER BOULEVARD HAVELOCK, NC 28532

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 5	F 578		

record (EMR) revealed an active order dated 4/28/23 for full code (cardiopulmonary resuscitation [CPR] should be performed in the event his heart should stop).

A review of Resident #31's physical chart revealed no advanced directives or code status orders.

In an interview with Nurse #1 on 7/8/24 at 11:50 AM she stated that she checked the EMR for code status when a resident's health declined. Nurse #1 accessed Resident #31's EMR and the information indicated Resident #31 was a full code. She then checked Resident #31's physical chart under advance directives, and it contained no advanced directives. She then checked the orders and was unable to locate a code status order. Nurse #1 stated it was the responsibility of the Social Worker (SW) to update the physical charts with advanced directives.

During an interview with the SW on 7/9/24 at 8:17 AM she stated she was responsible for ensuring the residents' physical charts had the correct advanced directives. The SW further stated she had been in the position for about 5 weeks and had checked resident charts that had been admitted since she started but had not checked the physical charts of residents that had been admitted before she started.

During an interview with the Director of Nursing (DON) on 7/9/24 at 1:08 PM she stated Resident #31 should have had advanced directives in the physical chart that matched the code status on the EMR.

During an interview with the Administrator on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345487	A. BUILDING _____ B. WING _____	C 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY POINT BAY NURSING AND REHABILITATION CENTER	110 MCCOTTER BOULEVARD HAVELOCK, NC 28532

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 6 7/9/24 at 1:35 PM she stated Resident #31 should have had advanced directives in the physical chart that matched the code status in the EMR.	F 578		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to label and date foods stored in 1 of 1 nourishment refrigerator located at the central nurse's station. This practice had the potential to affect food served to residents. Findings included: During an observation of the nourishment refrigerator located at the central nurse's station	F 812	F 812 Procurement, Store/Prepare/Serve On 7/9/24, the Dietary Manager discarded all unlabeled and undated items in the nourishment room refrigerator located at the central nurse's station. On 7/9/24, the Dietary Manager completed an audit of all nourishment rooms to ensure all food items were dated	8/2/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345487	A. BUILDING _____ B. WING _____	C 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY POINT BAY NURSING AND REHABILITATION CENTER	110 MCCOTTER BOULEVARD HAVELOCK, NC 28532

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 7 on 7/9/24 at 2:30 pm with the Certified Dietary Manager (CDM) present multiple food items were observed unlabeled without open or discard date. In addtion, a typed sign was observed on the outside of the refrigerator that read in part: "label and date food items with date opened and discard 3 days after opening of non-consumed foods." a. One white fast food paper bag with a partially consumed wrapped sandwich that was hard to the touch. It did not contain an open or discard date. b. One approximately 8-ounce clear plastic food storage container with a red lid noted with an a grayish-brown food with an unidentifiable white substance floating on top. It did not contain an open or discard date. c. One plastic produce bag that contained two plums, which did not contain an open or discard date. d. One opened 32-ounce ½ full bottle of a dairy based creamer with an expiration date of 10/8/24 from the manufacturer. It did not contain an open or discard date. e. One clear gallon sized plastic storage bag that contained an approximately 8-ounce size block of orange cheese with a creamy white substance noted on the edges of the cheese. Droplets of water were noted to adhere to the bag. It did not contain an open or discard date, f. One opened bottle of cranberry juice was noted to be ½ full with a best by date from the manufacturer of 7/30/24 stamped on the container. It did not contain an open. g. One opened, partially empty clear plastic container of kosher dill pickles with a sell by date from the manufacturer of 1/23/24 stamped on the container. It did not contain an open.	F 812	and/or expired items were discarded per facility protocol. The Dietary Manager addressed all concerns identified during the audit to include discarding food items when indicated. On 7/9/2024, the Staff Development Coordinator (SDC) initiated an in-service with all dietary staff, regarding Food Storage-Dating and Labeling Food Items with emphasis on ensuring items are dated per facility protocol and all expired items removed and discarded in accordance with professional standards for food service safety. This in-service will be completed by 8/2/24. After 8/2/24, any dietary staff who have not worked or received the in-service will complete the in-service prior to the next scheduled work shift. All newly hired dietary staff will be in-serviced during orientation regarding Food Storage- Dating and Labeling Food Items. On 7/9/2024 the SDC initiated an in-service with all nurses and nursing assistants regarding Food Storage-dating and labeling food items with emphasis on ensuring items are dated per facility protocol and all expired items removed and discarded in accordance with professional standards for food service safety. This in-service will be completed by 8/2/24. After 8/2/24, any nurses or nursing assistants who have not worked or received the in-service will complete the in-service prior to the next scheduled work shift. All newly hired nurses and/or nursing assistants will be in-serviced	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345487	A. BUILDING _____ B. WING _____	C 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY POINT BAY NURSING AND REHABILITATION CENTER	110 MCCOTTER BOULEVARD HAVELOCK, NC 28532

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 8 h. One opened 16-ounce 1/2 full bottle of mayonnaise with an expiration date from the manufacturer of 12/26/24. It did not contain an open. During the refrigerator observation the CDM discarded all unlabeled undated foods. In an interview with Nurse Aide (NA) # 1 on 7/09/24 at 02:35 she stated any food placed in the nourishment refrigerator should be dated with the date it had been put in the refrigerator and uneaten food should be discarded after 3 days. She stated that she received training when she was hired and annually. In an interview with Tray Aide #1 on 7/10/24 at 9:28 am she stated that she sometimes stocked the nourishment refrigerator, and she labeled the foods that she stocked with the date that it was placed in the refrigerator and removed food that was not labeled with a date. She stated pull dates differed based on the on the food type, and if it was prepackaged or had been opened, like pudding. She stated foods that were opened had a pull date of 3 days after it was opened. In an interview with Nurse #2 on 7/09/24 at 2:40 pm she stated that anything that is put into the nourishment refrigerator should be dated with the date it was put in the refrigerator and discarded after 3 days if not consumed. She stated that she was trained by the Staff Development Coordinator. In an interview with Nurse #1 on 7/11/24 at 9:14 am she stated that it was everyone's responsibility to maintain the nourishment refrigerator and that dietary stocked it with	F 812	during orientation regarding Dating Food Items. The dietary manager, nurse manager, and/or the SDC will audit all food storage areas weekly x 4 weeks then monthly x 1 month utilizing the Food Storage Monitoring tool. This audit is to ensure all food items in were dated and/or expired items were discarded per facility protocol. The dietary manager, nurse manager, and/or the SDC will address all concerns identified during the audit to include removing all expired items and/or items not labeled per facility protocol and education of staff. The Administrator will review the Food Storage Monitoring tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The dietary manager will present the findings of the Food Storage Monitoring tool to the Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The QAPI Committee will meet monthly for 2 months and review the Food Storage Monitoring tools to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345487	A. BUILDING _____ B. WING _____	C 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY POINT BAY NURSING AND REHABILITATION CENTER	110 MCCOTTER BOULEVARD HAVELOCK, NC 28532

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 9	F 812		

pudding and juices. She stated that if anyone saw foods that were outdated or unlabeled that they should have discarded them. The interview further revealed that personal foods should be labeled by staff with the date that it was put in the refrigerator. She further indicated that the unit manager maintained the refrigerator but that she no longer worked at the facility, so everyone worked together to keep it maintained and clean.

During an interview with the Staff Development Coordinator on 7/09/24 at 3:10 pm she stated that food in the nourishment refrigerator should be dated with an open date and thrown out after 24 to 48 hours but was unsure. The interview further revealed there was a little magnetized basket stuck to the nourishment refrigerator with labels and markers so staff could label items with dates.

During an interview with the CDM on 7/9/24 at 2:38 pm she indicated that dietary was responsible for monitoring the nutrition refrigerator daily and that she had checked that refrigerator on the morning of 7/9/24. She stated that she looked for discard dates for foods that she stocked the refrigerator with like juices, puddings, and prepackaged dietary supplements. She further stated that when she was not available her staff would check the refrigerator. She further stated that nursing also had a responsibility to check the refrigerator for outdated foods that belonged to residents, and they should have put the date opened or if it was a food brought in from restaurant it should be labeled with the date it was placed in the refrigerator and discarded within 3 days and referred to the sign on the refrigerator door.

In a follow-up interview with the CDM on 7/10/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345487	A. BUILDING _____ B. WING _____	C 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY POINT BAY NURSING AND REHABILITATION CENTER	110 MCCOTTER BOULEVARD HAVELOCK, NC 28532

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 10	F 812		

at 9:20 am she stated that she had a list of use by dates that she followed in the kitchen. She stated that any kitchen rules should have applied to the nourishment refrigerator. During the interview she stated that different foods had different discard dates that applied to them.

In an interview with the Director of Nursing on 7/10/24 at12:55 pm she stated that food in the nourishment refrigerator should have been labeled and dated with the open date or the date it had been put in the refrigerator. She further indicated that the facility policy was not specific, and the facility followed kitchen policy and guidelines for food storage.

In an interview with the Administrator on 7/10/24 at 8:32 am she stated the policy used in the kitchen for labeling of foods stored in the refrigerator applied to the nourishment refrigerator at the nurse's station. She stated that any food stored in the nourishment refrigerator should have been labeled with resident names, dates opened, or date that the food was placed in the refrigerator. She stated the discard dates were the same as for the kitchen.