STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255322	A. BUILDING _____ B. WING _____	01/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNBAR VILLAGE TERRACE	725 DUNBAR AVE BAY SAINT LOUIS, MS 39520

(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 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey and Complaint Investigation (CI), CI MS #23851, at the facility from 01/17/24 through 01/19/24. The SA investigated CI MS #23851 regarding dietary services and quality of care including food contamination, food cold, residents being left alone in dining room while eating, freezers and refrigerator temperatures not kept up to date, hot box does not work, and disposal to sink not working properly. There were no citations related to the complaint investigation. During the annual recertification survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F656, F690, F693, F700, and F758. The facility had a census of 57 at time of survey and was licensed for 60.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F 656		2/27/24

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

Electronically Signed | 02/08/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255322	A. BUILDING _____ B. WING _____	01/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNBAR VILLAGE TERRACE	725 DUNBAR AVE BAY SAINT LOUIS, MS 39520

(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 656	Continued From page 1 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to develop comprehensive care plan interventions related to a resident with full length bed rails (Resident #1) and a resident with an indwelling catheter (Resident #52) for two (2) of 17 sampled residents.	F 656	1. A comprehensive care plan was developed for Resident #1 by Licensed Practical Nurse (LPN) #2 (Minimum Data Set/Care Plan Nurse) on 1/20/2024 related to full-length bed rails. Resident #1 was evaluated by Assistant Director of Nurses (ADON) on 1/20/2024 to ensure no negative side effects due to not	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255322	A. BUILDING _____ B. WING _____	01/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNBAR VILLAGE TERRACE	725 DUNBAR AVE BAY SAINT LOUIS, MS 39520

(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 656	Continued From page 2 Findings include: Review of the facility's policy," Comprehensive Care Plans", revised 7/29/2019, revealed, " Policy Statement: An individual comprehensive care plan that includes measurable objectives and time frames to meet the resident's medical, nursing, mental, and psychological needs is developed for each resident..." Resident #1 During an observation on 01/17/24 at 12:08 PM, Resident #1 had full length bed rails on both sides of the bed. The resident explained she does not remember how long she had the bed rails. She stated she was not able to lower the rails on her own and asked staff to lower them for her at times, but there were times that she wanted to have the bed rails raised as well. She said she was unable to get up without assistance and she was unable to walk. A review of the medical record revealed there was no care plan for Resident #1 regarding the use of full-length bed rails. A record review of the "Admission Record" revealed the facility admitted Resident #1 on 11/29/2018 with diagnoses that included Spastic Diplegic Cerebral Palsy. A record review of the Quarterly Minimum Date Set (MDS,) with an Assessment Reference Date (ARD) of 11/09/23, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated she was cognitively intact. On 01/19/24 at 01:15 PM, an interview with	F 656	developing comprehensive care plan interventions related to full-length bed rails. A comprehensive care plan was revised for Resident #52 by LPN #2 on 1/18/2024 to include the intervention for staff to apply a leg strap/anchor to secure the indwelling catheter tubing. Resident #52 was evaluated by Director of Nurses (DON) on 1/18/24 to ensure no negative side effects due to failing to develop a comprehensive care plan related to leg strap/anchor to secure the indwelling catheter tubing. 2. Any resident with full-length bed rails can be affected by not developing a comprehensive care plan. Any resident with an indwelling catheter can be affected by not revising the comprehensive care plan. 3. An audit of all residents with full-length bed rails was initiated and completed on 1/19/2024 by the Maintenance Director. The audit reflected that no other residents were found to have full-length bed rails. All licensed nurses were inserviced by the Director of Nurses (DON) on 1/31/2024 to be completed on 2/8/2024 on Comprehensive Care Plans to include full-length bed rails. All comprehensive care plans for residents with indwelling catheters were reviewed to ensure a leg strap/anchor was included by the DON on 2/2/2024. The findings were recorded on the Comprehensive Care Plan and Catheter Leg Strap/Anchor Audit Form. All licensed nurses were inserviced by the DON beginning on 1/31/2024 to be completed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255322	A. BUILDING _____ B. WING _____	01/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNBAR VILLAGE TERRACE	725 DUNBAR AVE BAY SAINT LOUIS, MS 39520

(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 656	Continued From page 3 Licensed Practical Nurse (LPN) #2 (Minimum Data Set/Care Plan Nurse) revealed Resident #1 did not have a care plan addressing the full-length bed rails. LPN #2 explained the resident uses her own bed and she was unaware that the resident's bed had full length bed rails. On 01/19/24 at 03:00 PM, an interview with the Director of Nursing (DON) and the Administrator revealed they both expected the Care Plan nurse to develop a care plan to include all the resident's concerns and needs. Resident #52 During an observation on 1/17/24 at 12:38 PM, revealed Resident #52 had an indwelling catheter, and the catheter tubing was not anchored to the resident's leg to stabilize the catheter and prevent possible trauma. On 1/18/24 at 10:35 AM, during an observation and interview with the DON and Resident #52, Resident #52 stated she did not have a catheter anchor strap attached to her leg and no one at the facility had provided her with one. The resident revealed she had been using the leg straps from the leg drainage bag to try to hold the tubing in place. The DON provided the resident with a leg anchor to hold the tubing in place and the resident stated, "This feels good." A record review of the medical record revealed there was no Care Plan intervention for staff to apply a leg strap to secure the indwelling catheter tubing to prevent possible trauma. Record review of the "Admission Record" revealed the facility admitted Resident #52 on	F 656	by 2/8/2024 on Comprehensive Care Plans related to indwelling catheters to include leg strap/anchor. 4. The Maintenance Director to complete monthly bed rail audits to include identifying any full-length bed rails beginning 1/19/2024. This bed rail audit will continue monthly as a maintenance routine audit. Findings are reported to the Administrator and DON. Discrepancies are reported to the Quality Assessment and Assurance (QAA) team on a monthly basis to determine if further action is needed. The DON is to review comprehensive care plans for residents with indwelling catheters to ensure a leg strap/anchor and record findings on the Comprehensive Care Plan and Catheter Leg Strap/Anchor Audit Form beginning 2/2/2024 and on a monthly basis for three consecutive months. The DON will report findings to the Quality Assessment and Assurance (QAA) team on 2/27/2024 and monthly thereafter for one quarter to determine if further action is needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255322	A. BUILDING _____ B. WING _____	01/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNBAR VILLAGE TERRACE	725 DUNBAR AVE BAY SAINT LOUIS, MS 39520

(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 656	Continued From page 4 10/5/2023 with diagnoses that included Chronic Kidney Disease and Obstructive Reflux Uropathy. Record review of the Admission MDS with an ARD of 10/16/23 revealed Resident #52 had a BIMS score of 14 which indicated she was cognitively intact. On 1/19/24 at 1:06 PM, an interview with LPN #2 confirmed she was responsible for developing and updating the comprehensive care plans and the updates. She stated that an indwelling catheter leg strap or anchor was not addressed on Resident #52's care plan and it should have been addressed. LPN #2 stated care plans were developed and were individualized for residents to ensure consistency of care, which helped improve services for the residents.	F 656		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an	F 690		2/27/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255322	A. BUILDING _____ B. WING _____	01/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNBAR VILLAGE TERRACE	725 DUNBAR AVE BAY SAINT LOUIS, MS 39520

(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 690	Continued From page 5 indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to ensure an indwelling catheter tubing was stabilized to prevent trauma and failed to provide incontinence care in a manner to prevent complications for two (2) of three (3) residents observed for incontinence and catheter care. Resident #29 and #52. Findings Include: A review of the facility's policy "Perineal Care", dated 10/2023, revealed " ... Peri (Perineal) care helps prevent skin breakdown of perineal area, itching, burning, odor, and infections. Perineal care is very important in maintaining the resident's comfort ... Policy ... 8. Gently clean the skin of the perineal area moving from front to back. Do not move from back to front due to the risk of introducing germs ... Males: Retract	F 690	1. Resident #52 was evaluated by the Director of Nurses (DON) on 1/18/2024 to ensure no distress or negative side effects due to failing to ensure an indwelling catheter tubing was stabilized to prevent trauma. The DON placed a leg strap/anchor on 1/18/2024 to ensure the indwelling catheter tubing was stabilized to prevent trauma. Resident #29 was evaluated by the Assistant Director of Nurses (ADON) on 1/19/2024 to ensure no distress or negative side effects due to failing to provide proper incontinence care. The Certified Nursing Assistant (CNA) who failed to provide proper incontinence care was counseled on 1/19/2024 by the Lead Certified Nursing Assistant (CNA). 2. Any resident with an indwelling catheter can be affected by failing to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255322	A. BUILDING _____ B. WING _____	01/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNBAR VILLAGE TERRACE	725 DUNBAR AVE BAY SAINT LOUIS, MS 39520

(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 690	Continued From page 6 foreskin in uncircumcised male. Grasp penis, clean tip of penis using a circular motion, wash down shaft of the penis and wash testicles. Replace foreskin of uncircumcised male ..." A review of the facility's policy "Indwelling Catheter Use and Removal," undated, revealed, " Policy: It is the policy of this village to ensure that indwelling urinary catheters that are inserted or remain in place are justified according to regulations and current standards of practice ...Compliance guidelines ...7. Additional care practices include ...d. Keeping the catheter anchored to prevent excessive tension on the catheter, which can lead to urethral tears or dislodgement of the catheter..." Resident #29 On 01/19/24 at 09:25 AM, during an observation and interview with Certified Nurse Aide (CNA) #4, she reported Resident #29 was usually incontinent in the mornings and used a urinal during the daytime while he was awake. There was a strong urine odor in the resident's room and the resident's brief was saturated with urine. CNA #4 assisted Resident #29 to the toilet, removed the saturated brief, and performed incontinence care as he stood up in the bathroom. CNA #4 used an incontinence disposable wipe and cleaned the genital area, including the left and right groin area, and the scrotum and did not use a new wipe or change the position of the wipe with each stroke. CNA #4 did not clean the penis. After CNA #4 completed the incontinence care, she confirmed that she did not discard the disposable incontinence wipe or change the position of the wipe to ensure a clean area of the wipe was used with each stroke. CNA	F 690	ensure the indwelling catheter tubing is stabilized by using a leg strap/anchor. Any resident can be affected by failing to provide proper incontinence care. 3. All residents with indwelling catheters were checked to ensure they had a catheter leg strap/anchor in place on 1/18/2024 by the ADON. All licensed nurses and certified nursing assistants (CNA) were inserviced on Indwelling Catheter Use and Removal by the DON beginning 1/25/2024 to be completed by 2/8/2024. All Certified Nursing Assistants (CNA) were inserviced by the DON beginning on 1/29/2024 with completion by 2/8/2024 on Perineal Care. Perineal Care Checkoffs were completed on all CNAs by the Licensed Nurse Supervisors beginning on 1/29/2024 with completion by 2/8/2024. 4. All licensed nurses to be educated by the Licensed Nurse Supervisor upon hire and at least annually on catheter care to include leg strap/anchor. The Licensed Nurse Supervisors will observe leg strap/anchor placement on residents with catheters beginning 2/2/2024 and monthly thereafter for three consecutive months. Observations will be recorded on the Comprehensive Care Plan and Catheter Leg Strap/Anchor Placement Audit Form. The findings to be reported to the Quality Assessment and Assurance (QAA) team by the DON on 2/27/2024 and monthly thereafter for one quarter to determine if further action is needed. All CNAs will be inserviced on proper perineal care with the completion of a perineal care checkoff upon hire by a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255322	A. BUILDING _____ B. WING _____	01/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNBAR VILLAGE TERRACE	725 DUNBAR AVE BAY SAINT LOUIS, MS 39520

(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 690	Continued From page 7 #4 also confirmed she did not clean the penis. On 01/19/24 at 10:10 AM, during an interview with Lead CNA #1, she explained CNA #4 should have used a new wipe with each stroke and should have cleaned the penis as part of incontinence care. She explained CNA#4 received training and a competency check-off when hired. On 01/19/24 at 03:00 PM, during an interview with the Director of Nursing (DON), she explained she expected the CNAs to follow the proper procedures with incontinence care. A record review of the "Admission Record" revealed the facility Resident #29 on 05/19/21 with diagnoses that included Benign Prostatic Hyperplasia (BPH) without Lower Urinary Tract Symptoms. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/16/23 revealed Resident #29 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated his cognition was moderately impaired. A record review of the "Perineal Care Competency Audit", dated 10/19/23, revealed CNA #4 completed training with Lead CNA #1 regarding perineal care. Resident #52 On 1/17/24 at 12:38 PM, during an observation, Resident #52 had an indwelling catheter, and the catheter tubing was not anchored to the resident's leg to stabilize the catheter and prevent possible	F 690	Licensed Nurse Supervisor and annually thereafter. Perineal care checkoff to be completed on two CNAs per week beginning 2/12/2024 for one month by a Licensed Nurse Supervisor. The DON will review and report findings to the QAA team on 2/27/2024 and monthly thereafter to determine if further action is needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255322	A. BUILDING _____ B. WING _____	01/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNBAR VILLAGE TERRACE	725 DUNBAR AVE BAY SAINT LOUIS, MS 39520

(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 690	Continued From page 8 trauma. During an observation and interview with the DON and Resident #52, on 1/18/24 at 10:35 AM, Resident #52 stated she did not have a catheter anchor strap attached to her leg and no one at the facility had provided her with one. The resident revealed she had been using the leg straps from the leg drainage bag to try to hold the tubing in place. The DON provided the resident with a leg anchor to hold the tubing in place and the resident stated, "This feels good." On 1/18/24 at 10:53 AM, an interview with the DON confirmed that Resident #52 did not have a leg strap to anchor and stabilize the catheter tubing and the resident confirmed that she liked the support of the leg strap when the DON placed it on the resident. The DON stated the indwelling catheter anchors were to be placed on residents' legs so that the catheter is anchored to prevent tension on the catheter and bladder. Record review of the "Admission Record" revealed the facility admitted Resident #52 on 10/5/2023 with diagnoses that included Chronic Kidney Disease and Obstructive Reflux Uropathy. Record review of the Admission MDS with an ARD of 10/16/23 revealed Resident #52 had a BIMS score of 14 which indicated she was cognitively intact.	F 690		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and	F 693		2/27/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255322	A. BUILDING _____ B. WING _____	01/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNBAR VILLAGE TERRACE	725 DUNBAR AVE BAY SAINT LOUIS, MS 39520

(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 693	Continued From page 9 percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to date and label a tube feeding bag for one (1) of (1) residents reviewed for tube feeding management. (Resident #4) Findings include: A review of the facility's policy "Care and Treatment of Feeding Tubes", undated, revealed, "Policy: It is a policy of this village to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible ..." On 01/17/24 at 12:36 PM, during an observation, Resident #4 was lying in bed with the head of the bed elevated. There was a tube feeding running	F 693	1. Resident #4 was evaluated by the Assistant Director of Nurses (ADON) on 1/17/2024 to ensure no distress or negative side effects due to failing to date, time and label the tube feeding bag and water bag. The Licensed Practical Nurse (LPN) who failed to date, time and label the tube feeding bag and water bag was counseled by the Registered Nurse on 1/18/2024. 2. Any resident who is fed by enteral means can be affected by failing to date, time and label the tube feeding bag and water bag. 3. All licensed nurses were inserviced by the Director of Nurses (DON) beginning on 1/30/2024 with completion by 2/8/2024 regarding Care and Treatment of Feeding	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255322	A. BUILDING _____ B. WING _____	01/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNBAR VILLAGE TERRACE	725 DUNBAR AVE BAY SAINT LOUIS, MS 39520

(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 693	Continued From page 10 at 70 cc (cubic centimeters)/hour (hr). The tube feeding formula bag did not contain a date, time, or label indicating when the bag of tube feeding was started. The bag had a manufacturer's label indicating the type of feeding as Isosource. There was a bag of water that did not contain a date, time, or label indicating when the water flush was started. On 01/17/24 at 4:16 PM, during an observation and interview with Licensed Practical Nurse (LPN) #6, she confirmed that the feeding and water did not contain a date, time, or label indicating when the bag of tube feeding or water was started. She stated that the bags should include a label with the date and time so staff will know how long the tube feeding has been flowing and to ensure a resident does not receive old formula. LPN #6 said that it was the facility's policy to label the tube feeding daily when a new bag was hung. On 01/19/24 at 04:05 PM, during an interview with the Director of Nursing (DON), she explained she expected staff to follow standard procedures for labeling tube feeding and all nurses had been educated on proper labeling. A record review of "Admission Record" revealed the facility admitted Resident #4 on 02/07/23 with a diagnoses that included Acute Respiratory Failure with Hypoxia and Gastrostomy Complication. A record review of the Quarterly Minimum Data Set with an Assessment Reference Date of 12/05/23 revealed Resident #4 was coded as having a feeding tube.	F 693	Tubes. 4. Spot checks to be completed by a Licensed Nurse Supervisor two times a week for four weeks to ensure the tube feeding bag and water bag is dated, timed and labeled beginning 1/30/2024 with completion on 2/27/2024. All weekly spot checks to be reported to the Director of Nurses. The findings of the spot checks to be reviewed by the DON weekly and presented to the Quality Assessment and Assurance (QAA) team on 2/27/2024 and on a monthly basis to determine if further action is needed. All nurses upon hire will be inserviced on proper tube feeding management.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255322	A. BUILDING _____ B. WING _____	01/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNBAR VILLAGE TERRACE	725 DUNBAR AVE BAY SAINT LOUIS, MS 39520

(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 693	Continued From page 11 A record review of the "Order Summary Report", with active orders as of 01/18/2024, revealed Resident #4 had a Physician's Order, dated 8/31/23 for "Enteral Feed Order ...Continuous Feed: Isosource 1.5 to 70 ml (milliliter)/hr."	F 693		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews the facility failed to inform a resident or the Resident Representative (RR) of the risk and benefits of full length bed rails prior to bed rail installation for one (1) of 17 sampled residents. Resident #1	F 700	1. Resident #1 was evaluated by Assistant Director of Nurses (ADON)on 1/20/2024 to ensure no distress or negative effects due to failing to inform the resident of the risk and benefits of full-length bed rails prior to bed rail	2/27/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255322	A. BUILDING _____ B. WING _____	01/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNBAR VILLAGE TERRACE	725 DUNBAR AVE BAY SAINT LOUIS, MS 39520

(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 700	Continued From page 12 Findings include: Record review of the facility's statement, dated 1/19/2024, provided by the Administrator revealed, " (Proper Name of Facility) does not have a policy on bed rails." On 01/17/24 at 12:08 PM, during an observation, Resident #1 had full length bed rails on both sides of the bed. The resident explained she does not remember how long she had the bed rails. She stated she was not able to lower the rails on her own and asked staff to lower them for her at times, but there were times that she wanted to have the bed rails raised as well. She said she was unable to get up without assistance and she was unable to walk. On 01/18/24 at 03:00 PM, during an observation and interview with Licensed Practical Nurse (LPN) #3, she confirmed Resident #1 had full length bed rails and has had them for as long as she could remember. On 01/19/24 at 11:30 AM, during an interview with the Maintenance Director, she confirmed Resident #1 had her own bed that was donated to her from another resident and the bed had full length bed rails. A review of the medical record revealed there was no informed consent indicating the risk and benefits of full-length bed rails signed by the resident or RR. On 01/19/24 at 03:00 PM, during an interview with the Administrator, she confirmed Resident #1 had full length bed rails and there was no signed	F 700	installation. 2. Any resident with full-length bed rails can be affected by not informing of the risk and benefits of full-length bed rails prior to installation. 3. Resident #1 was informed of the risk and benefits of full-length bedrails on 1/20/2024 by the Assistant Director of Nurses (ADON). An audit of all residents with full-length bed rails was initiated and completed on 1/19/2024 by the Maintenance Director to determine if any residents with full-length bed rails needed to be informed of the risk and benefits. The audit reflected that no other residents were found to have full-length bed rails. The Administrator inserviced the Maintenance Director, Maintenance Technician, Director of Nurses and Licensed Nurse Supervisors on 2/1/2024 regarding completing the Bed Rails Informed Consent for Use when a resident requests full-length bed rails prior to installation. 4. The Maintenance Director to complete monthly bed rail audits to include identifying any full-length bed rails beginning 1/19/2024. This bed rail audit will continue monthly as a maintenance routine audit. Findings are reported to the Administrator and Director of Nurses. Discrepancies are reported to the Quality Assessment and Assurance (QAA) team by the Administrator and/or Maintenance Director on 2/27/2024 and on a monthly basis thereafter to determine if further action is needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255322	A. BUILDING _____ B. WING _____	01/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNBAR VILLAGE TERRACE	725 DUNBAR AVE BAY SAINT LOUIS, MS 39520

(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 700	Continued From page 13 informed consent related to the bed rails. She said the facility did not have a policy regarding bed rails and the facility was planning on addressing the problem but had not gotten to it yet. A record review of the "Admission Record" revealed the facility admitted Resident #1 on 11/29/2018 with a diagnoses that included Spastic Diplegic Cerebral Palsy. A record review of the Quarterly Minimum Date Set (MDS,) with an Assessment Reference Date (ARD) of 11/09/23, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated she was cognitively intact.	F 700		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F 758		2/27/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255322	A. BUILDING _____ B. WING _____	01/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNBAR VILLAGE TERRACE	725 DUNBAR AVE BAY SAINT LOUIS, MS 39520

(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 758	Continued From page 14 §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to ensure PRN (as needed) psychotropic medications were discontinued after 14 days or had a documented indication for continued use by the prescriber, with a designated time frame for one (1) of five (5) residents reviewed for unnecessary medications. Resident #44 Findings include:	F 758	1. Resident #44 was evaluated by Assistant Director of Nurses (ADON) on 1/19/2024 to ensure that no distress or negative effects due to failing to ensure as needed (PRN) psychotropic medications were discontinued after 14 days or had a documented indication for continued use by the prescriber, with a designated time frame. 2. Any resident receiving PRN	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255322	A. BUILDING _____ B. WING _____	01/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNBAR VILLAGE TERRACE	725 DUNBAR AVE BAY SAINT LOUIS, MS 39520

(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 758	Continued From page 15 Review of the facility's policy, "Use of Psychotropic Medication," undated, revealed, " Policy: Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s) ... Policy Explanation and Compliance Guidelines: 9. PRN orders for all psychotropic drugs shall be used only when the medication is necessary to treat a diagnosed specific condition that is documented in the clinical record, and for a limited duration (i.e.14 days) a. If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she shall document their rationale in the resident's medical record and indicate the duration for the PRN order ..." Review of Resident #44's "Order Summary Report," with active orders as of 01/01/24, revealed orders for Lorazepam Concentrate 2 mg/ml (milligram/milliliter) give 0.5 ml by mouth every 4 (four) hours as needed for anxiety with an order date of 9/28/23, Lorazepam Injection solution 2 mg/ml inject 2 millimeters intramuscularly every 6 (six) hours as needed for agitation, with an order date of 9/27/23, and Lorazepam oral concentrate 2 mg/ml give 0.5 ml by mouth every 6 (six) hours as needed for agitation and shortness of breath, with an order date of 9/27/23. None of the above psychotropic medications had a stop date. Review of the "Admission Record," for Resident #44 revealed the facility admitted the resident to	F 758	psychotropics can be affected by failing to ensure PRN psychotropic medications were discontinued after 14 days or had a documented indication for continued use by the prescriber, with a designated time frame. 3. All licensed nurses were inserviced beginning on 1/25/2024 with completion by 2/8/2024 by the Registered Nurse (RN) regarding Use of Psychotropic Medications □ PRN. An audit of all residents with a PRN psychotropic medication was completed on 1/25/2024 by the DON to ensure all psychotropic medications were discontinued after 14 days or had a documented indication for continued use by the prescriber, with a designated time frame. 4. A weekly audit was initiated by the Director of Nurses (DON) on 1/30/2024 for 4 consecutive weeks of all PRN psychotropics to ensure they are discontinued after 14 days or have documentation indicating continued use by the prescriber with a designated time frame. Findings are to be reported to the Quality Assessment and Assurance (QAA) by the Director of Nurses on 2/27/2024 and on a monthly basis thereafter to determine if further action is needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255322	A. BUILDING _____ B. WING _____	01/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNBAR VILLAGE TERRACE	725 DUNBAR AVE BAY SAINT LOUIS, MS 39520

(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 758	Continued From page 16	F 758		

the facility on 12/5/22, with diagnoses that included Senile Degeneration of the Brain, not elsewhere classified, Vascular Dementia, Unspecified Psychosis, and Depression.

Review of the Comprehensive Minimum Data Set (MDS), with an Assessment Reference Date (ARD) 12/5/23, revealed Resident #44 had been unable to complete the Brief Interview for Mental Status (BIMS) and the staff documented that the resident's cognitive skills for decision making were moderately impaired.

On 01/19/24 12:54 PM, in an interview with Assistant Director of Nursing (ADON), she confirmed that Resident #44's orders for Lorazepam should have been discontinued after 14 days, as that is the facility policy.

On 01/19/24 at 1:47 PM, in an interview with the Nurse Practitioner (NP), she stated she was aware that psychotropic medications needed to have a stop state date of 14-days, but for some reason, the Lorazepam had been missed on Resident #44.