STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255322	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNBAR VILLAGE TERRACE	725 DUNBAR AVE 725 DUNBAR AVE, BAY SAINT LOUIS, Mississippi, 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
F0000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 7/28/25 through 7/31/25. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F658, F812, and F842. The facility had a census 57 and was licensed for 60 beds.	F0000		08/14/2025
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to ensure services were provided in accordance with professional standards of practice observed during medication administration when the nurse allowed Resident #11 to self-administer two (2) different prescribed nasal sprays without assessing whether he was capable of doing so safely for one (1) of four (4) residents observed. (Resident #11). Findings include: A review of the facility's policy titled "Resident Self-Administration of Medication," with a reviewed/revised date of 5/2025, revealed, "…It is the policy of this village to support each residents' right to self-administer medication. A resident may only self-administer medications after the village's interdisciplinary team has determined which medications may be self-administered safely… Policy Explanation and Compliance Guidelines…4. The results of the interdisciplinary team assessment are recorded on the	F0658	The following plan of correction is not intended to be an admission of guilt or used for any purpose other than the purpose stated herein. On 7/30/25 Resident #11 was assessed by the Director of Nursing to ensure that there were no negative signs and symptoms due to the resident administering two (2) nasal spray of medication to each nostril instead of one without completion of self-administration assessment. On 7/31/25, A Resident Self-Administration Assessment was completed on Resident #11 by Director of Nursing. Any resident has the potential to be affected by failing to ensure services were provided in accordance with professional standards of practice. On 7/31/25, Registered Nurse Supervisor began inservicing all nurses that residents should not be self-administering medications until the Resident Self-Administration Assessment has been completed. Inservicing completed on 8/4/25. An audit was completed on 7/31/25 on all residents to determine who prefers to self-administer medication. On 8/12/25, the Director of Nursing, inserviced all nurses on the resident self-administration policy and process. On 8/6/25, the agenda to village daily stand-up, which all staff attends, was updated to include the nurses reporting on any resident who has a preference of self-administering medications to ensure that a Resident Self-Administration Assessment has been completed. On 8/12/25 and 8/14/25, the Director of Nursing added to the monthly nurses meeting to review all residents who prefer to self-administer medication to ensure that a	09/03/2025

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 reverse for further 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

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F0658 SS = D	Continued from page 1 Medication Self-Administration Assessment Form, which is placed in the resident's medical record…" On 7/30/25 at 8:32 AM, during a medication administration observation, Licensed Practical Nurse (LPN) #2 was observed administering two (2) nasal spray medications to Resident #11: Azelastine Hydrochloride (HCL) Solution 137 micrograms (mcg)/spray and Fluticasone Propionate Nasal Suspension 50 mcg/actuation. LPN #2 instructed Resident #11 to self-administer one (1) spray to each nostril for both medications. Resident #11 was observed administering two (2) sprays to each nostril of the Fluticasone. LPN #2 stated that the resident usually administered his own nasal sprays but confirmed she was unsure whether the resident had been assessed to self-administer. She acknowledged that the resident used two (2) sprays of Fluticasone, although the order specified one (1) spray to each nostril. On 7/30/25 at 10:10 AM, during an interview with Resident #11, he stated the nurse always gave him his nasal sprays, but he administered them himself. He explained he always gave himself two (2) sprays of each medication because it made it easier for both him and the nurse. On 7/31/25 at 9:37 AM, during an interview with the Director of Nursing (DON), she stated there were no residents in the facility who had been assessed or had physician orders to self-administer medications. She acknowledged being aware that Resident #11 administered his own nasal sprays but explained that if a resident could not follow dosage instructions, they would not qualify for self-administration. She confirmed it was her expectation that all nurses ensure a resident has been assessed for self-administration and that medications are administered in accordance with physician orders. A record review of the "Admission Record" revealed the facility admitted Resident #11 on 11/6/24 with diagnoses including Dementia. A record review of the "Order Summary Report" with active orders as of 7/31/25, revealed Resident #11 had a Physician's Order for Fluticasone Propionate Nasal Suspension, dated 3/14/25 for "1 (one) spray in both nostrils two (2) times a day for Rhinitis," and there were no orders noted for self-administration. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/30/25 revealed Resident #11 had a Brief Interview for Mental	F0658	Continued from page 1 Resident Self-Administration Assessment has been completed. Residents who self-administer a medication will be monitored by a medication cart nurse one time per week for 4 weeks during the self-administration, then monthly for three months thereafter beginning 8/18/25 to ensure correct administration. Any concerns will be brought to the nurse supervisor and/or Director of Nursing for observation and re-assessment if necessary. Findings of the Quality Assessment and Performance Improvement will be reported to the Quality Assessment and Assurance Committee on 9/3/25 and monthly times three months thereafter for review. Any systemic changes will be made as needed. The revisions will be developed and approved by the Quality Assessment and Assurance Committee to ensure the Plan of Correction is achieved and sustained. The Quality Assessment and Assurance Committee includes but is not limited to the Medical Director or Registered Nurse Practitioner, Administrator, Director of Nursing, Infection Preventionist, and at least two other members of the staff.	

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F0658 SS = D	Continued from page 2 Status (BIMS) score of 13, which indicated he was cognitively intact. A review of the electronic health record (EHR) and paper chart revealed there was no “Self-Administration Assessment Form” completed for Resident #11.	F0658		
F0812 SS = D	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, interview, and the facility’s ServSafe (a food safety training and certification program) documentation review, the facility failed to ensure that food was stored in a safe and sanitary manner to prevent contamination and deterioration for one (1) of two (2) kitchen observations. Findings include: A review of the facility’s ServSafe document “The Flow of Food: Purchasing, Receiving and Storing”, dated 2020, revealed, “… Receiving and Inspecting…make sure enough trained staff are available to receive and inspect food items promptly … Food Quality…Appearance Reject food that is moldy or has an abnormal color … Do	F0812	The following plan of correction is not intended to be an admission of guilt or used for any purpose other than the purpose stated herein. All identified fruit was discarded immediately by the Dietary Manager on 7/28/25 upon discovery. Cups were immediately removed from the flour and sugar bin by the Dietary Manager on 7/28/25 upon discovery. All residents have the potential to be affected by failing to ensure that food is stored in a safe and sanitary manner to prevent contamination and deterioration. On 7/31/25, the Dietary Manager inserviced all dietary staff on the storage of produce having a seven-day shelf life and the process of visually inspecting at time of arrival and time of preparation. On 7/31/25, the Dietary Manager inserviced all dietary staff that no items, such as cups, to be in the storage bins in order to prevent cross contamination. The Dietary Manager or Maintenance Supervisor will monitor the refrigerator, freezer, and dry goods area weekly times four weeks then every two weeks for three months beginning 8/5/2025 to ensure all foods are stored in a safe and sanitary manner to prevent contamination and deterioration. Findings of the Quality Assessment and Performance Improvement will be reported to Quality Assessment and Assurance Committee on 9/3/25 and monthly thereafter for review. Any systemic changes will be made as needed. The revisions will be developed and approved by the Quality Assessment and Assurance Committee to ensure the Plan of Correction is achieved and sustained. The Quality Assessment and Assurance Committee includes, but is not limited to, the Medical Director (or his designee), Administrator, Director of Nursing, Infection Preventionist, and at least two other staff members.	09/03/2025

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F0812 SS = D	Continued from page 3 not overload coolers or freezer to prevent good air flow, use open shelving …" On 7/28/25 at 10:15 AM, during an observation of the kitchen and an interview with the Dietary Manager (DM), seven (7) pints of strawberries with visible mold were observed on a cardboard flat between two (2) flats of grapes in the walk-in cooler. Additionally, eight (8) oranges with a dried appearance, mold, and soft texture, and two (2) lemons with green and black mold were observed. The DM confirmed the fruit was stored for resident consumption and explained that the fruit was typically inspected at the time of use. He acknowledged that the oranges were from that morning's snack cart. In the dry storage room, a drinking cup was observed stored inside the flour bin and a measuring cup was observed stored inside the sugar bin. Both cups were in direct contact with the food product and were being used as scoops. The DM immediately removed the cups and confirmed they had been in use. On 7/28/25 at 11:40 AM, during an interview with the Registered Dietitian (RD), she stated that she had been informed of the kitchen findings by the DM. She explained that the molded fruit was discarded immediately and confirmed that the cups were removed from the flour and sugar bins. On 7/31/25 at 10:31 AM, during an interview with the Administrator, she stated that the fruit found in the cooler had not been served to residents. After being informed that the oranges were found on the morning snack cart and that fruit is routinely served with meals, the Administrator acknowledged that kitchen staff had daily opportunities to identify and remove unfit fruit. She also confirmed she had been made aware of the findings of cups being used as scoops and being stored in the flour and sugar bins.	F0812		
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.	F0842	The following plan of correction is not intended to be an admission of guilt or used for any purpose other than the purpose stated herein. On 7/29/25, Resident #5 was assessed by the Director of Nursing to ensure there were no negative signs or symptoms due to the Nurse Practitioner visit notes not being readily accessible to the licensed nursing staff. All Nurse Practitioner visit notes were uploaded to Point Click Care electronic health records for Resident #5 by the medical records clerk on 7/29/25. All residents may have the potential to be affected by failing to ensure that all clinical records are readily	09/03/2025

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F0842 SS = D	Continued from page 4 §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches	F0842	Continued from page 4 accessible to licensed nursing staff. On 7/29/25, the Director of Nursing began inservicing all nursing staff where to find the Nurse Practitioner visit notes in the electronic health record. Inservicing completed on 8/4/25. All Nurse Practitioner visit notes were uploaded to Point Click Care electronic health records for all residents by the Medical Records Clerk or Admissions Coordinator beginning 7/29/25 with completion by 8/27/25. Beginning on 8/1/25, the Nurse Practitioner began uploading her visit notes to the electronic healthcare system upon completion. The Medical Records Clerk or Admissions Coordinator will complete a weekly audit beginning 8/4/25 to ensure that the Nurse Practitioner visit notes are uploaded to be readily accessible for licensed nursing staff. This audit will be completed weekly for four weeks then monthly for three months. Findings of the Quality Assessment and Performance Improvement will be reported to the Quality Assessment and Assurance Committee on 9/3/25 and monthly thereafter for review. Any systemic changes will be made as needed. The revisions will be developed and approved by the Quality Assessment and Assurance Committee to ensure the Plan of Correction is achieved and sustained. The Quality Assessment and Assurance Committee includes, but is not limited to, the Medical Director (or his designee), Administrator, Director of Nursing, Infection Preventionist, and at least two other members of the staff.	

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F0842 SS = D	Continued from page 5 legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that all clinical records, including nurse practitioner (NP) visit notes, were readily accessible to licensed nursing staff responsible for resident care for one (1) of 15 sampled residents, Resident #5, with the potential to affect fifty-seven (57) residents who reside in the facility. Findings include: On 7/28/25 at 1:54 PM, during an observation and interview, Resident #5 was observed wearing a right wrist splint. The resident explained she fell at home and broke her femur and wrist. She stated she continued to have some pain but received pain medications as ordered and that the nurse practitioner recently changed how often she could receive them. On 7/29/25 at 1:10 PM, during an interview with Licensed Practical Nurse (LPN) #1 she stated Resident #5's pain medication frequency was recently changed from every four (4) hours to every six (6) hours. She explained she typically reviewed progress notes in the EHR for any changes related to residents and confirmed there were no progress notes from the NP in the EHR for Resident #5. On 7/29/25 at 1:15 PM, during an interview with the Director of Nursing (DON), she reviewed EHRs on her computer and explained the NP visited Resident #5 on	F0842		

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F0842 SS = D	Continued from page 6 7/11/25 because the resident was discharged from the hospital with a ten (10)-day supply of Norco. She stated the NP notes were entered into a separate system that was only accessible to facility management. She confirmed the notes were not accessible to floor nurses and stated that if a nurse needed information regarding what occurred during a NP visit, they would need to call the NP directly or contact the on-call nurse. She acknowledged this process was unconventional but was a method that could be used for clarification if a nurse had a question about what occurred during a NP visit. The DON confirmed the NP sees all residents in the facility upon admission, annually, and as needed. On 7/30/25 at 8:30 AM, during an interview with the Administrator, she stated the facility communicated changes in resident care, including new physician orders, during morning meetings and through messaging within the EHR system. The Administrator explained the facility transitioned to an EHR system that was not compatible with the NP's software and therefore could not be viewed by the floor staff. The provider's progress notes not being readily accessible in resident charts were something that had fallen through the cracks during the software transition. A record review of the "Admission Record" revealed the facility admitted Resident #5 on 6/25/25 with current diagnoses including Aftercare Following Joint Replacement Surgery. A record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/2/25 revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated she was cognitively intact.	F0842		