Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(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
M0000	Initial Comments The State Agency (SA) conducted an annual recertification survey at the facility from 7/28/25 to 7/31/25. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and cited M735 and M815.	M0000		08/14/2025
M0735	45.25.1 Medical Records Management Medical Records Management. 1. A medical record shall be maintained in accordance with accepted professional standards and practices on all residents admitted to the facility. The medical records shall be completely and accurately documented, readily accessible, and systematically organized to facilitate retrieving and compiling information. 2. A sufficient number of personnel, competent to carry out the functions of the medical record service, shall be employed. 3. The facility shall safeguard medical record information against loss, destruction, or unauthorized use. 4. All medical records shall maintain the following information: identification data and consent form; assessments of the resident's needs by all disciplines involved in the care of the resident; medical history and admission physical exam; annual physical exams; physician or nurse practitioner/physician assistant orders; observation, report of treatment, clinical findings and progress notes; and discharge summary, including the final diagnosis. 5. All entries in the medical record shall be signed and dated by the person making the entry.	M0735	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 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	09/03/2025

Office of Primary Care and Health Systems Management

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

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M0735	Continued from page 1 Authentication may include signatures, written initials, or computer entry. A list of computer codes and written signatures must be readily available and maintained under adequate safeguards. 6. All clinical information pertaining to the residents stay shall be centralized in the resident's medical records. 7. Medical records of discharged residents shall be completed within sixty (60) days following discharge. 8. Medical records are to be retained for five (5) years from the date of discharge or, in the case of a minor, until the resident reaches the age of twenty-one (21), plus an additional three (3) years. 9. A resident index, including the resident's full name and birth date, shall be maintained. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II 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 all fifty-seven (57) residents who resided 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	M0735	Continued from page 1 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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M0735	Continued from page 2 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 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.	M0735		
M0815	45.29.1 Safe Food Handling Procedures Safe Food Handling Procedures. Food shall be prepared, held, and served according to current Mississippi State Department of Health Food Code Regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, 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	M0815	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	09/03/2025

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M0815	Continued from page 3 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 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.	M0815	Continued from page 3 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.	