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 _____	07/25/2019

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DUNBAR VILLAGE TERRACE	725 DUNBAR AVE BAY SAINT LOUIS, MS 39520

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey along with a complaint survey, CI MS #15942 from 7/23/19 to 7/25/19. Complaint CI MS #15942 was related to Admission, Transfer, and Discharge Rights. During the survey, the SA did not substantiate the complaint, and no deficiencies were cited related to the complaint. The SA also determined the facility was not in substantial compliance with the requirements of participation for Medicare and Medicaid. The SA cited the deficiencies F637, F656, F657, F690, and F812. The census was 62 at the time of the survey entrance, and the facility held a license for 70 beds.	F 000		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review, and facility policy review, the facility failed to complete Resident #45's comprehensive Significant	F 637	1. Resident #45 has no negative effects due to not completing the comprehensive Significant Change in Status (SCSA)	9/4/19

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

Electronically Signed | 08/16/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 637	Continued From page 1 Change in Status (SCSA) Minimum Data Set (MDS) assessment within 14 days of determining the resident's status change was significant, for one (1) of 19 residents reviewed. Findings include: A review of the facility's policy titled, "Completion of MDS Assessments", undated, revealed it was the policy to complete the MDS assessments for all elders within the village by use of the Resident Assessment Instrument (RAI) Manual 2.0 to accurately reflect the elder's status and to complete within the mandated timeframe per Centers for Medicare and Medicaid Services (CMS) regulations. A review of the most recent comprehensive Significant Change (SC) MDS assessment, with an Assessment Reference Date (ARD) of 6/21/19, revealed the MDS was coded to include hospice services. A review of the July 2019 Physician's Orders, revealed an order, dated 6/8/19, for (Name of Hospice Service) for the diagnosis Cerebral Atherosis/Dementia. A review of the Comprehensive Care Plan revealed the Problem/Need for the diagnosis of Athrosclerosis and the resident and family decided not to pursue aggressive treatment and has chosen (Name of Hospice Services) for the resident's comfort and care. Interventions included hospice care will be provided as ordered by the physician. A review of the medical record revealed the facility did not complete the comprehensive SC	F 637	Minimum Data Set (MDS) Assessment within 14 days of determining the resident's status change of admitting to hospice. 2. Any resident can be affected by failing to complete the comprehensive SCSA MDS assessment within 14 days of determining the resident's status change of admitting to hospice. 3. Registered Nurse (RN) #1/MDS Coordinator and Licensed Practical Nurse (LPN) #1/MDS and Care Plan Coordinator were inserviced on 7/25/19 by the Director of Nurses (DON) on the Resident Assessment Instrument (RAI) 3.0 Manual "Significant Change in Status Assessment (SCSA)". All medical records of residents currently receiving hospice services were audited by the RN #1/MDS Coordinator on 7/26/19 to ensure that the comprehensive SCSA MDS assessments were completed within 14 days of hospice admission and none were found to be deficient. The Interdisciplinary Team (IDT), consisting of the Nurse Practitioner, DON, Administrator, Registered Nurses, Licensed Nurses, Certified Nursing Assistants, Therapists, and Social Service Director, was inserviced beginning 7/30/19 with completion on 8/6/19 by the DON on the RAI SCSA and re-educated to continue to use the Village Communicator form at each daily stand-up in review of all residents to ensure timely completion of the comprehensive SCSA MDS assessment within 14 days of determining the status was significant. 4. All residents admitted to hospice will	

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F 637	Continued From page 2 MDS assessment within 14 days of determining the status change was significant. Review of Resident #45's SC MDS, with an ARD of 6/21/19, revealed the completion date was 7/5/19 as evidenced by the staff signature dates for the Registered Nurse (RN) Assessment Coordinator for completion of the assessment, the RN Coordinator for the CAA (Care Assessment Areas) Process, and the Signature of the Person Completing the Care Plan was all dated 7/5/19. The resident was admitted to hospice services on 6/8/19, and the comprehensive SC MDS had an ARD of 6/21/19. On 7/25/19 at 12:13 PM, an interview with the Director of Nurses (DON) revealed the resident was transferred to the hospital in March and May of 2019 for Sepsis. She stated the resident was placed on hospice services after the last hospital stay. Review of the Transfer and Discharge sheet dated, 3/25/19, and an Effective Date of 3/23/19, revealed Resident #45 was transferred to the hospital for higher level of care. Review of the hospital Discharge Summary revealed Resident #45 was admitted to the hospital, on 3/23/19, due to a decrease in her abilities and mental status over the past two days. The principal problem was Severe Sepsis, Alzheimer's Dementia without behavioral disturbance and Weakness. Resident #45 was discharged back to the nursing home on 3/26/19, in fair condition, and continuation of antibiotics by mouth. Review of the Transfer and Discharge sheet dated 5/20/19, and an Effective Date of 5/17/19, revealed Resident #45 was transferred to the hospital for a higher level of care. Review of the	F 637	be reviewed monthly for three months by the Director of Nurses to ensure that the comprehensive SCSA MDS assessments were completed within 14 days of hospice admission. Findings will be reviewed and reported to the Quality Assurance and Assessment (QAA) Team, which consists of the DON, Medical Director, Nursing Home Administrator and at least two other staff members that meets at least on a quarterly basis, on 9/4/19 by the DON and in one quarter to determine if further action is needed.	

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F 637	Continued From page 3 hospital Discharge Summary revealed Resident #45 was admitted to the hospital, on 5/17/19, due to altered mental status. The principal problem was Sepsis, Acute Cystitis without hematuria, and Hypokalemia. Resident #45 was discharged back to the nursing home on 5/22/19 in good condition, and to continue antibiotics by mouth. On 7/25/19 at 2:15 PM, an interview with Registered Nurse (RN) #1/MDS Coordinator, revealed the most recent comprehensive SC MDS assessment with an ARD of 6/21/19, was not completed within 14 days of determining the status change was significant. On 7/25/19 at 2:44 PM, an interview with the DON revealed she would expect the staff to complete the MDS in a timely manner, to include transmission. A review of the facility's Face Sheet revealed the facility admitted Resident #45 on 11/6/15, with a diagnosis of Dementia.	F 637		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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	F 656		9/4/19

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F 656	Continued From page 4 or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and facility policy review, the facility failed to implement the comprehensive care plan related to catheter care for one (1) of two (2) care plans reviewed for catheters, for Resident #34. Findings include: A review of the facility's policy titled, "Care Plan-	F 656	1. The care plan related to catheter care to include catheter securement device for Resident #34 was reviewed on 7/24/19 by the Registered Nurse (RN) #1/Minimum Data Set (MDS) Coordinator. Certified Nurse Assistant(CNA) #2 counseled by the Director of Nurses (DON) on 7/24/19 on not following the care plan to include catheter securement	

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F 656	Continued From page 5 Comprehensive," undated, revealed it was the policy of this facility an individual Comprehensive Care Plan included measurable objectives and timetables to meet the elder's (resident) medical, nursing, and mental and psychosocial needs, shall be developed for each elder (resident). The facility policy stated that the facility's care planning team, in coordination with the elder (resident), his/her family or representative develops and maintains a Comprehensive Care Plan for each elder (resident). Review of Resident #34's Comprehensive Care Plan revealed a Problem/Need at risk for Urinary Tract Infection (UTI) due to Resident #34 having chronic urinary retention and a diagnosis of Neurogenic Bladder disorder. The Onset Date was 6/2/2016. The Approaches included the Certified Nursing Assistants (CNAs) was to check the catheter and ensure the catheter was secured to the elder's (resident) thigh with a catheter securement device to prevent excessive movement and minimize accidental removal. Review of the facility's document, "Giving Indwelling Catheter Care", no date, revealed the seven (7) Equipment List items to be gathered included tape or a leg strap. This document was provided when a facility policy for catheter care was requested. Review of Resident #34's July 2019 Physician's Orders revealed an order, dated 3/24/2017, for a Foley catheter, for a diagnosis of Neuromuscular Dysfunction of the Bladder. The order stated that the catheter was also ordered due to a diagnosis of Urinary Retention. The order included instructions for catheter care to ensure that the catheter did not malfunction or was accidentally	F 656	device for Resident #34. Registered Nurse (RN) #2/Assistant Director of Nursing (ADON) placed catheter securement device on Resident #34 on 7/24/19. Resident #34 was assessed by the DON on 7/25/19 to ensure no distress or negative side effects evident due to failing to implement the comprehensive care plan related to catheter care. 2. Any resident can be affected by failing to implement the comprehensive care plan related to catheter care. 3. All five residents with a catheter care plan were checked to ensure the placement of a catheter securement device by Registered Nurse (RN) on 7/24/19. All Nurses and Certified Nurse Assistants (CNA) were inserviced by the RN beginning 7/25/19 with completion on 8/1/19 on following the care plan related to catheter care. All Nursing Staff will be inserviced by the RNs upon hire and quarterly thereafter on following the care plan related to catheter care. Catheter care observations were begun on all CNAs for residents with a catheter care plan by the RNs on 7/29/19 with planned completion on 8/30/19. Observation findings recorded on the Quality Assessment Performance Improvement (QAPI) Catheter Care Audit Tool. 4. Findings of the Quality Assessment Performance Improvement (QAPI) Catheter Care Audit Tool will be reviewed and presented to the Quality Assurance and Assessment (QAA) Team by the DON on 9/4/19 and in one quarter to determine if further action is needed.	

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F 656	Continued From page 6 removed. Further review of the July 2019 Physician's Orders revealed an order, dated 10/26/2017, for catheter care, as well as the instruction that the catheter was to be secured to Resident #34's thigh with a catheter securement device to prevent excessive movement and minimize accidental removal. An observation, on 7/24/2019 at 2:21 PM, revealed Certified Nursing Assistant (CNA) #2 provided Resident #34's catheter care. It was observed at that time Resident #34 did not have a catheter strap in place before catheter care began. During the catheter care, CNA #2 put Resident #34 at risk for injury or discomfort, by holding the catheter tubing at the Y connection, instead of close to the meatus. CNA #2 was observed to be cleaning the catheter tubing away from the body in the correct direction. CNA #2 did not provide a catheter strap to Resident #34's thigh/leg to secure the catheter tubing, and prevent tugging or pulling on the tubing. An interview, on 7/24/2019 at 2:28 PM, revealed Certified Nursing Assistant (CNA) #2 confirmed Resident #34 did not have a catheter strap in place. CNA #2 stated, "I should have held the catheter tubing close to the body when cleaning the tubing, so that that the tubing won't pull and hurt the resident or come out." CNA #2 stated, "It must have come off, cause (sic) she usually has one on." During a follow-up observation on 7/24/2019 at 4:29 PM, with Registered Nurse (RN) #2/Assistant Director of Nursing (ADON), it was revealed there was no catheter strap or securing device in place for Resident #34's catheter tubing, who was lying in bed, in her room. An interview at	F 656		

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F 656	Continued From page 7 this time with the Assistant Director of Nursing (ADON) confirmed Resident #34 did not have a securing device for the catheter tubing. The ADON stated that a securing device for the catheter tubing helps to prevent tugging and possible pain and injury, if the catheter came out. The ADON stated that the tubing should be held closer to the body to prevent injury or preventing the dislodgement of the catheter, during care. The ADON stated that the catheter care if not done correctly, could be an infection control problem. During an interview, on 7/25/2019 at 8:56 AM, Registered Nurse (RN) #1/Care Plan and Minimum Data Set (MDS) Coordinator revealed it was her intention that the focused problems have approaches that are to be followed by the staff providing care. RN #1 stated that care is to include the use of a catheter strap. RN #1 stated that securing the catheter tubing close to the body when cleaning, is correct. RN #1 stated, "If the CNA failed to clean the catheter tubing properly and failed to provide a securing devise for the tubing, the current care plan was not followed. During an interview, on 7/25/2019 at 11:30 AM, the Director of Nursing (DON revealed it is her expectation that the care plan should reflect the resident's current and complete status. The DON stated that the care plan should be followed as indicated by the problems and interventions that have been assessed by the Interdisciplinary (ID) Team. Review of the Face Sheet revealed Resident #34 was admitted by the facility, on 5/20/2016, with diagnoses to include Cerebral Infarction and Neuromuscular Dysfunction of Bladder.	F 656		

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F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, and staff interview, the facility failed to revise the Comprehensive Care Plans to include updated interventions, and reflect the current resident status related to falls for two (2) of 19 care plans reviewed. Resident #33 and Resident #40.	F 657	1. Residents #33 and #40 have no negative side effects due to not revising the comprehensive care plans to include updated interventions and to reflect the current status related to falls. The care plan related to falls for Residents #33 and #40 were reviewed and updated on 7/25/19 by the Registered Nurse (RN)	9/4/19

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F 657	Continued From page 9 Findings Include: Review of the undated facility policy titled, "Care Plan- Comprehensive," revealed it is the policy of this facility that an individual Comprehensive Care Plan that includes measurable objectives and timetables to meet the elder's (resident) medical, nursing, and mental and psychosocial needs, shall be developed for each elder (resident). The facility policy stated that the facility's Care Planning Team, in coordination with the elder (resident), his/ her family or representative develops and maintain a Comprehensive Care Plan for each elder (resident). The facility policy stated that the Comprehensive Care Plan is based on a through [sic] assessment that includes, but is not limited to, the Minimum Data Set (MDS). The facility policy also stated that the assessments of the elders (residents) are ongoing and care plans are revised as information about the elder (resident) and the elder's (resident) conditions change. Review of the facility'd policy titled, "Dunbar Village Care Plan Review Policy and Procedure," dated 4/2014, revealed that it is the policy of this facility that the care planning process will be initiated after completion of the MDS assessment to ensure inclusion of the most recent assessment data. The facility policy stated that identified discrepancies will generate additional assessments by the MDS team and the care plan will be modified as necessary to reflect the current needs and capacities of the resident in question. The facility's policy procedure stated that the Care Plan Nurse will compare the completed MDS assessment to identify areas that need to be completed on the Care Plan and identify any discrepancies. The facility's policy	F 657	#1/Minimum Data Set (MDS) Coordinator. Fall mat of Resident #33 was removed by Registered Nurse (RN)#2/Assistant Director of Nurses (ADON) on 7/25/19 to reflect the current resident status. 2. Any resident can be affected by not revising the comprehensive care plans to include updated interventions and to reflect the current status related to falls. 3. An audit of all resident fall care plans to reflect current resident status was begun by the Registered Nurses (RN) on 7/25/19 with planned completion on 8/30/19. Findings recorded on the Fall Care Plan Audit Tool. Any identified discrepancies were/will be immediately updated by the RNs to reflect the current status of falls. All Licensed Nurses were inserviced on Comprehensive Care Plans by the Director of Nurses (DON) on 7/30/19 and will be inserviced quarterly thereafter. 4. Findings of the Fall Care Plan Audit Tool will be reviewed and presented to the Quality Assurance and Assessment (QAA) Team by the DON on 9/4/19 and in one quarter to determine if further action is needed.	

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F 657	Continued From page 10	F 657		

procedure stated that the Care Plan calendar will offset the MDS calendar to allow completion of the MDS assessment. The facility's policy procedure also stated that identified discrepancies will generate additional assessment by the MDS team and modification of the care plan as necessary to reflect the current needs and capacities of the resident in question.

Resident #33

Review of Resident #33's Care Plan, revealed the Problem/ Need, with an onset date of 7/1/14, for at risk for injury/ falls due to impaired cognition, poor safety awareness, and is legally blind, this puts her at risk for injury/falls. The goal stated Resident #33 will have no falls thru 10/12/2019. The Approaches (interventions) included: A Fall mat is to be placed by the side of Resident #33's bed while she is in bed; Resident #33 is to wear non-skid socks; The nursing department is to notify Resident #33's Medical doctor (MD) and Resident #33's family as needed; The nursing department is to provide any needed medical treatment (TX) for lacerations, hematoma, or other injuries; The nursing department is to perform Neuro checks with falls with head injuries; The nursing department is to perform medication review for potential side effects, and is to check on Resident #33 more frequently when episodes of disorganized thinking occur.

During the initial tour of the facility, on 7/23/2019 at 11:05 AM, an observation revealed a four (4) inch fall mat was laying on the floor next to Resident #33's bed.

Review of Resident #33's Significant Change Minimum Data Set (MDS), with an Assessment

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F 657	Continued From page 11 Reference Date (ARD) of 12/7/2018, revealed section C1310C documented no disorganized thinking or behavior was present. The MDS also indicated in the J1800 section, that Resident #33 had no falls since the prior assessment. Review of Resident #33's Quarterly MDS, with an ARD of 3/1/2019, revealed section C1310C documented no disorganized thinking or behavior was present. The MDS also indicated in the J1800 section, Resident #33 had no falls since the prior assessment. Review of Resident #33's Quarterly MDS, with an ARD of 5/22/2019, revealed section C1310C documented no disorganized thinking or behavior was present. The MDS also indicated in the J1800 section, Resident #33 had no falls since the prior assessment. During an interview, on 7/25/2019 at 8:36 AM, Licensed Practical Nurse (LPN) #1/ MDS and Care Plan Coordinator, confirmed Resident #33's care plan does not accurately reflect the resident's current status. LPN #1 stated that based on the past three (3) MDS assessments, the current Problem/Need on Resident #33's care plan, for being at risk for falls, was not accurate. LPN #1 stated that although Resident #33 is still at risk for falls, the current interventions are not appropriate and did not reflect the current status of Resident #33. During an interview, on 7/25/2019 at 11:30 AM, the facility's Director of Nursing (DON) stated it is her expectation that the care plan should reflect the resident's current and complete status. The DON stated the care plan should be followed as indicated by the problems and interventions that	F 657		

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F 657	Continued From page 12 have been assessed by the Care Planning Team/ Interdisciplinary (ID) team. The DON stated the care plan should be revised as any status regarding the resident's care changes. Review of the Face Sheet revealed Resident #33 was admitted by the facility, on 8/29/2003 and re-admitted on 8/8/2013, with diagnoses to include Cerebral Infarction and Senile Degeneration of the Brain. Review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/22/2019, revealed Resident #33 had a Brief Interview of Mental Status (BIMS) score of three (3), indicating severely impaired cognition. Resident #40 Review of Resident #40's Comprehensive Care Plan revealed the Problem/Need, with an onset date of 7/5/18, for potential risk for falls/injury related to impaired cognition, legally blind, weakness, dizziness, and Left Lower Extremity Parestharia (feeling of numbness, tingling, itching, or pins and needles), and History of Falls. The Goal stated the resident would remain free from injuries. Approaches included: Remind several times throughout the day to call for assistance. Keep call light within easy reach. Bed in low position, place fall mat near bed, notify family and physician of fall, provide any needed medical treatment for laceration, hematoma or other injuries, neuro checks for falls and head injuries, keep in well populated area for supervision, medication review for potential side effects as needed, send evaluation to Therapy Department, and care partners to do frequent checks throughout the day as possible. Further	F 657		

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F 657	Continued From page 13	F 657		

review of the Care Plan revealed hand written under the Problem/Need column were Actual Fall dates on 6/10/18, 11/28/18 and 7/7/19.

A review of the facility's Accident and Incident Reports revealed, Resident #40 had a fall on the following days: 6/10/18, 11/28/18 (x2), 1/27/19, 4/27/19, and 7/7/19. The comprehensive care plan was not updated to include interventions after a fall on 11/28 (x1) and 4/27/19.

On 7/23/19 at 10:10 AM an observation revealed, Resident #40 sitting in her chair in her room talking to her daughter.

A review of the most recent Annual MDS assessment, with an ARD of 5/24/19, revealed the MDS was coded to indicate Resident #40 required limited assistance x1 person with transfers, walking in room, walking in corridor, extensive assistance x1 person with locomotion on unit and was coded to include falls since prior assessment. This MDS assessment also indicated Resident #40 had a Brief Interview of Mental Status (BIMS) score of 10 (moderate cognitive impairment). There were no behaviors indicated on the MDS assessment. The Discharge MDS assessment, return not anticipated, with an ARD of 6/22/18, was not coded to include falls, but was prior to the last survey.

On 7/25/19 at 9:27 AM, an interview with the Director of Nurses (DON), revealed the staff normally try to figure out the situation when a fall occurs and put interventions in place. She stated the staff try interventions such as floor mats, changing their toileting schedule, looking for patterns to see if the facility could change up

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F 657	Continued From page 14 anything. She also stated most of the time the staff makes sure they (referring to the residents) have a floor mat and if the resident does not, the staff will place one beside the bed. The DON stated the staff will look at other incidences, such as the time of the fall and have other situational meetings with the team like a huddle and will get the Nurse Practitioner's (NP) input. The DON stated a new intervention is put in place within 24 hours of a fall occurring. She stated the Registered Nurses (RNs) are responsible for making sure the interventions are in place. She also stated falls are an actual problem for this resident. The DON stated she would say the resident would probably not remember education given to her from the staff. She stated the care plan was not updated to include both falls that occurred on 11/28/18, or interventions put in place after the fall that occurred on 4/27/19. She also stated the comprehensive care plan has not been updated enough to accurately reflect this resident and to prevent further falls. On 7/25/19 at 9:36 AM, an interview with RN #1, revealed the comprehensive care plan was updated after each fall. She stated falls was an actual problem for this resident and not a potential for a problem. She also stated educating the resident was not an appropriate intervention because the resident has a moderately impaired cognition. She stated the care plan was not updated to include interventions that the resident had fallen twice on 11/28/18. She stated there were no interventions put in place after the fall on 4/27/19. RN #1 stated the comprehensive care plan does not accurately reflect the resident regarding falls. On 07/25/19 at 11:28 AM, an interview with the	F 657		

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F 657	Continued From page 15 DON, revealed she would expect the comprehensive care plan to reflect everything that the staff is currently doing for the resident. A review of the facility's Face Sheet revealed the facility admitted Resident #40, on 5/10/18 and she was readmitted on 6/25/18, with diagnoses of Diabetes Mellitus and Legal Blindness.	F 657		
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 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.	F 690		9/4/19

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F 690	Continued From page 16 §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, record review, facility policy review, and staff interview, the facility failed to provide proper catheter care to prevent the possibility of trauma to the bladder for one (1) of two (2) residents observed for catheter care. (Resident #34) Findings include: Review of the facility's document, "Giving Indwelling Catheter Care", no date, revealed the seven (7) Equipment List items to be gathered included tape or a leg strap. This document was provided when a facility policy for catheter care was requested. An observation, on 7/24/2019 at 2:21 PM, revealed Certified Nursing Assistant (CNA) #2 provided Resident #34's catheter care. It was observed at that time Resident #34 did not have a catheter strap in place before catheter care began. During the catheter care, CNA #2 put Resident #34 at risk for injury or discomfort, by holding the catheter tubing at the Y connection, instead of close to the meatus. CNA #2 was observed to be cleaning the catheter tubing away from the body in the correct direction. CNA #2 did not provide a catheter strap to Resident #34's thigh/leg to secure the catheter tubing, and prevent tugging or pulling on the tubing.	F 690	1. Resident #34 was assessed by the Director of Nurses (DON) on 7/25/19 to ensure no distress or negative side effects evident due to failing to provide proper catheter care to prevent the possibility of trauma to the bladder. Certified Nurse Assistant (CNA) #2 counseled by the DON on 7/24/19 to ensure catheter securement device and proper catheter care for Resident #34. Registered Nurse (RN) #2/Assistant Director of Nurses (ADON) placed catheter securement device on Resident #34 on 7/24/19. 2. Any resident can be affected by failing to provide proper catheter care to prevent the possibility of trauma to the bladder. 3. All five residents with catheterAll Nurses and Certified Nurse Assistants (CNAs) were inserviced by the RN beginning 7/25/19 with completion on 8/1/19 on proper catheter care. All Nursing Staff will be inserviced by the RNs upon hire and quarterly thereafter on proper catheter care. Catheter care observations were begun on all CNAs for residents with a catheter by the RNs on 7/29/19 with planned completion on 8/30/19. Observation findings recorded on the Catheter Care Competency Audit Tool. 4. Findings of the Catheter Care	

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F 690	Continued From page 17 An interview, on 7/24/2019 at 2:28 PM, revealed Certified Nursing Assistant (CNA) #2 confirmed Resident #34 did not have a catheter strap in place. CNA #2 stated, "I should have held the catheter tubing close to the body when cleaning the tubing, so that that the tubing won't pull and hurt the resident or come out." CNA #2 stated, "It must have come off, cause (sic) she usually has one on." Review of Resident #34's Comprehensive Care Plan revealed a Problem/Need at risk for Urinary Tract Infection (UTI) due to Resident #34 having chronic urinary retention and a diagnosis of Neurogenic Bladder disorder. The Onset Date was 6/2/2016. The Approaches included the Certified Nursing Assistants (CNAs) was to check the catheter and ensure the catheter was secured to the elder's (resident) thigh with a catheter securement device to prevent excessive movement and minimize accidental removal. Review of Resident #34's July 2019 Physician's Orders revealed an order, dated 3/24/2017, for a Foley catheter, for a diagnosis of Neuromuscular Dysfunction of the Bladder. The order stated that the catheter was also ordered due to a diagnosis of Urinary Retention. The order included instructions for catheter care to ensure that the catheter did not malfunction or was accidentally removed. Further review of the July 2019 Physician's Orders revealed an order, dated 10/26/2017, for catheter care, as well as the instruction that the catheter was to be secured to Resident #34's thigh with a catheter securement device to prevent excessive movement and minimize accidental removal.	F 690	Competency Audit Tool will be reviewed and presented to the Quality Assurance and Assessment (QAA)Team by the DON on 9/4/19 and in one quarter to determine if further action is needed.	

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F 690	Continued From page 18 During a follow-up observation on 7/24/2019 at 4:29 PM, with Registered Nurse (RN) #2/Assistant Director of Nursing (ADON), it was revealed there was no catheter strap or securing device in place for Resident #34's catheter tubing, who was lying in bed, in her room. An interview at this time with the Assistant Director of Nursing (ADON) confirmed Resident #34 did not have a securing device for the catheter tubing. The ADON stated that a securing device for the catheter tubing helps to prevent tugging and possible pain and injury, if the catheter came out. The ADON stated that the tubing should be held closer to the body to prevent injury or preventing the dislodgement of the catheter, during care. During an interview, on 7/25/2019 at 8:56 AM, Registered Nurse (RN) #1/Care Plan and Minimum Data Set (MDS) Coordinator confirmed securing the catheter tubing close to the body when cleaning, is correct. Review of the Face Sheet revealed Resident #34 was admitted by the facility, on 5/20/2016, with diagnoses to include Cerebral Infarction and Neuromuscular Dysfunction of Bladder.	F 690		
F 812 SS=F	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.	F 812		9/4/19

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F 812	Continued From page 19 (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 observations, staff interviews, and facility policy review, the facility failed to maintain the kitchen in a manner to prevent cross contamination and food borne illnesses as evidenced by: Two (2) unclean hand towels placed on the tray line during the tray line temperature checks, Dietary Staff failed to clean the thermometer with an alcohol pad after each food temperature item was checked on the tray line, failed to wash hands upon entrance to the kitchen and contact with kitchen items, and failed to wear a hair net and/or failed to wear a hair net that covered/secured all of the staff's hair. These concerns were identified for two (2) of five (5) kitchen observations. Findings include: A review of the facility's policy, dated 1/13, and titled, "Food Service Operational Standards for Purchasing, Cooking, and Storage, revealed the facility stores, prepares, distributes, and serves food under sanitary conditions to prevent the spread of food borne illness and to reduce those practices that result in food contamination and compromised food safety. The policy stated under 6. Cooking. d. Wash hands before handling	F 812	1. No known negative effects to any residents due to not maintaining the kitchen in a manner to prevent cross contamination and food borne illnesses. Dietary Staff #2 counseled by Dietary Manager on 7/24/19 on cross contamination of food contact surface. Dietary Staff #1 counseled by Dietary Manager on 7/24/19 on proper hand washing during food preparation. Certified Nursing Assistant (CNA) #1 was counseled by the Dietary Manager on 7/24/19 on proper hair restraint policy to include hand washing. Dietary Staff #5 and Dietary Staff #6 were counseled by Dietary Manager on 7/24/19 on proper hair restraint policy. 2. Any resident can be affected by not maintaining the kitchen in a manner to prevent cross contamination and food borne illnesses. 3. An inservice on proper handwashing and hair restraints was begun by Certified Dietary Manager (CDM) on 7/25/19 to all staff with completion on 8/2/19. An inservice on Hazard Analysis and Critical Control Point (HAACP) guidelines,	

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F 812	Continued From page 20 food, and after handling raw food, and after any interruption that may contaminate hands. Review of the policy revealed there were no procedures for wearing hair nets or cleaning the thermometer between food item temperature checks on the tray line. On 7/23/19 at 11:49 AM, an observation revealed Dietary Staff #2 checked the tray-line temperatures. Dietary Staff #2 checked the mashed potatoes, and then wiped the thermometer with an unclean, dingy white hand towel she had placed on the tray line before she began checking the tray line temperatures. Dietary Staff #2 checked the green bean temperature and continued to check the following food temperatures: Tomatoes mixed with zucchini, white rice, gumbo, and chopped meat. There were no concerns identified with the food temperatures. After Dietary Staff #2 checked the chopped meat, she wiped the thermometer with the unclean, dingy white hand towel she had placed on the tray line earlier, and then checked the gravy temperature. It was observed Dietary Staff #2 had placed two unclean, dingy, white hand towels on the tray line during the tray line service. On 7/24/19 at 11:00 AM, an observation revealed Dietary Staff #2 checked the tray-line temperatures for the ham and beans, rice, and gravy. Dietary Staff #2 used the same alcohol prep to wipe the thermometer before she checked the temperatures of the mashed potatoes, Brussel sprouts, cup of fruit, chicken pot pie, and okra and tomatoes. There were no concerns identified with the food temperatures. During the follow up visit, on 7/24/19 at 11:34 AM,	F 812	biological hazards and chemical hazards was presented to all dietary staff on 8/6/19 by (Name of Food Supplier) representative who is a Registered Dietician (RD)/Licensed Dietitian Nutritionist (LDN). An inservice on kitchen cloths, personal hygiene, handwashing, food safety and sanitation, and taking accurate food temperatures was presented to all dietary staff on 8/14/19 by CDM. Larger signs were placed outside of the kitchen entrance doors stating Dietary Staff Only on 8/6/19 by the CDM. The door code to the kitchen doors was changed by the Maintenance Director on 8/13/19 in which the dietary staff was directed by the CDM to not give code to non-dietary staff members. The Registered Dietitian (RD) and the CDM will monitor compliance with maintaining the kitchen in a manner to prevent cross contamination and food borne illnesses by doing weekly unannounced inspections on dietary staff beginning 8/12/19 with completion on 9/3/19. The findings of the inspections will be recorded on the Food Service Manager Self-Inspection Checklist. 4. Findings of the Food Service Manager Self-Inspection Checklist will be reviewed and presented to the Quality Assurance and Assessments (QAA) by the CDM on 9/4/19 and in one quarter to determine if further action is needed.	

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F 812	Continued From page 21 an observation revealed as Dietary Staff #4 was checking the food temperatures, he dropped an alcohol prep into the brown gravy. Dietary Staff #1 removed the brown gravy from the tray line and placed it on a table near where the dishes are washed. She then went into the dry storage room area, retrieved a packet of brown gravy, returned to a preparation table, opened the packet of dry gravy, poured the dry brown gravy into a pitcher, ran some cold water into the dry gravy from the sink and stirred it together. Dietary Staff #1 then applied clean gloves, however she did not wash her hands. She poured the brown gravy mixture into some boiling hot water that was on the stove and discarded the gravy that the alcohol prep had dropped into. On 7/24/19 at 2:17 PM, an observation revealed Certified Nursing Assistant (CNA) #1 walked into the kitchen without wearing a hair net and did not wash her hands upon entering the kitchen. She then turned around shortly after that and left the kitchen. On 7/24/19 at 2:19 PM, an observation revealed CNA #1 walked into the kitchen again, wearing a hair net, walked over to the ice chest, opened it up and looked inside of it. CNA #1 did not wash her hands after entering the kitchen or before opening the ice chest. On 7/24/19 at 2:39 PM, an observation revealed Dietary Staff #5 was wearing a hair net that left the braids at the back of her hair uncovered, and Dietary Staff #6 was observed to have a bandana on with part of the hair around the outer parts of her head uncovered, she did not have a hair net on.	F 812		

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F 812	Continued From page 22 On 7/24/19 at 2:42 PM, an interview with Dietary Staff #1, revealed Dietary Staff #2 should not have wiped the thermometer with a towel because lint could get in the food and because of cross contamination. She stated she (referring to herself/Dietary Staff #1) just did not wash her hands in between removing the contaminated gravy and making the new gravy. Dietary Staff #1 stated CNA #1 should have washed her hands between putting the ice in the cooler and when she entered the kitchen. Dietary Staff #1 stated, both Dietary Staff #5 and Dietary Staff #6 should have had a hair net on, and all of their hair should have been underneath the hair net. On 7/24/19 at 5:35 PM, an interview with the Dietary Manager, revealed Dietary Staff #5 should have worn a hair net large enough to restrict all of her hair, and Dietary Staff #6 should have had a hair net on with all of her hair restricted as well. The Dietary Manager stated CNA #1 should have had a hair net on when she entered the kitchen the first time and washed her hands and should have washed her hands after entering the kitchen the second time. The Dietary Manager stated Dietary Staff #2 said she had gotten nervous, and that is cross contamination for Dietary Staff #2 to have hand towels on the tray-line.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255322	A. BUILDING **01 - DUNBAR VILLAGE TERRACE** B. WING _____	**07/25/2019**

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
K 000	INITIAL COMMENTS The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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

Electronically Signed | 08/19/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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 _____	07/25/2019

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
E 000	Initial Comments ********** Survey conducted on 07/25/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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

Electronically Signed | 08/19/2019

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