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	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dunbar Village Terrace	725 Dunbar Ave Bay Saint Louis, MS 39520

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to ensure a resident was free from a significant medication error when facility staff administered undiluted Sertraline Hydrochloride (Zoloft) Oral Solution to a resident for one (1) of six (6) residents reviewed for medication review. (Resident #62) Findings include:A review of the facility's policy, Medication Errors, Date Reviewed/Revised 9/2025, revealed, Policy Explanation and Procedure: 1. The village shall ensure medications will be administered as follows.b. Per manufacturer's specifications regarding the preparation, and administration of the drug. A record review of the admission Record revealed the facility admitted Resident #62 on 2/27/26 with diagnoses including Aftercare Following Joint Replacement Surgery.A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/6/26 revealed Resident #62 had a Brief Interview for Mental Status (BIMS) score of thirteen (13), which indicated the resident was cognitively intact.A record review of the Pharmacy Requisition Report dated 03/02/2026 revealed the resident was ordered Sertraline Hydrogen Chloride (HCl) Oral Concentrate 20 milligrams (mg)/milliliter (ml) (Sertraline HCl) - Route: by mouth. A record review of the Medication Administration Record (MAR) for March 2026 revealed Resident #62 was administered Sertraline Hydrochloride Oral Concentrate 20 mg/ml on 3/6/26.A record review of the facility's Medication Incident Report Form dated 3/6/26 revealed the Type of Incident was documented as Other not mixed in liquid. The section titled What is the outcome or result of the incident? was documented as Other irritation to mouth. The Description of error was documented as, Liquid Zoloft not mixed in liquid. Mix in liquids no on apothecary directions . Corrective actions documented, spoke with pharmacy representative.regarding need for special instructions directly on pharmacy label .A review of the medication package revealed instructions on the front and back of the package stated, Must Be Diluted Before Use (see side panel for instructions). The side panel revealed, Mixing Instructions.mix with 4 oz (ounces) (1/2 cup) of water, ginger ale, lemon/lime soda, lemonade or orange juice ONLY .A review of the medication package insert revealed, Highlights of Prescribing Information.Zoloft (sertraline hydrochloride) oral solution.Dosage and Administration.Oral solution: Must be diluted .Preparation of Zoloft Oral Solution Zoloft oral solution must be diluted before use.Mix with 4 ounces (1/2 cup) of water, ginger ale, lemon/lime soda, lemonade, or orange juice ONLY.A record review of the Progress Notes, Type: Discharge summary, dated [DATE] revealed, A care partner alerted this nurse this afternoon at around 1300 that elder earlier received liquid sertraline without mixing in liquid, which resulted in elder complaining of a 'burning tongue' and 'sore throat.' Reported that the elder was given water after medication administered as well as soft foods to soothe the throat. Elder went to therapy and requested to return to room r/t sore throat and burning tongue. Reported that elder called her children to come to the village and she requested discharge today.On 5/27/26 at 8:10 AM, during an interview with the Resident Representative (RR), she reported that on 3/6/26 shortly after 1:00 PM, she received a phone call from Resident #62 and had difficulty understanding her. The RR stated she arrived at the facility approximately (25) minutes later and observed Resident #62 walking down the hall holding her neck while accompanied by a nurse. The RR reported Resident #62 told her that her throat was burning because the nurse did not mix her liquid (continued on next page)

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.

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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication. The RR stated she asked staff what had been done for the resident and was informed of the medication error. The RR reported she and her brother gathered Resident #62's belongings, transported her to the emergency room for evaluation, and then took her home because they did not intend for her to return to the facility.On 5/27/26 at 12:10 PM, during an interview with Registered Nurse (RN) #1/RN Supervisor, she reported the facility completed an incident report and medication error review after Resident #62 received liquid Zoloft without proper dilution. RN #1 explained the nurse administering medications gave the resident liquid Zoloft that should have been diluted and Resident #62 complained that her mouth was burning afterward. RN #1 reported the family arrived at the facility and was informed of the error. RN #1 stated Resident #62 complained of discomfort and was provided water, ice cream, and pudding. RN #1 reported the facility's Nurse Practitioner was notified.On 5/27/26 at 1:10 PM, during an interview with the Nurse Practitioner (NP), she stated she recalled being notified regarding Resident #62 receiving liquid Zoloft without dilution. The NP explained she contacted the pharmacy and was informed the medication should be diluted with at least four (4) ounces of liquid. The NP reported administration of undiluted liquid Zoloft could cause numbness, tingling, mouth soreness, throat soreness, and a burning sensation. The NP stated the recommendation was to continue fluids to help alleviate the symptoms.On 5/28/26 at 2:34 PM, during an interview with the Director of Nursing (DON), she recalled the incident involving administration of undiluted liquid Zoloft to Resident #62. The DON reported the family was upset regarding the medication error. The DON stated the medication arrived from the pharmacy without dilution instructions on the pharmacy label. The DON reported she contacted the pharmacist following the medication error and discussed the need for administration instructions to accompany medications. The DON stated nurses should look up administration instructions and obtain additional information when administering medications that are unfamiliar to them.On 5/28/26 at 2:54 PM, during a phone interview, Licensed Practical Nurse (LPN) #1 reported she recalled administering the medication to Resident #62. LPN #1 stated this was the first time she had administered liquid Zoloft. LPN #1 reported the medication packaging she reviewed contained dosing information, but she did not recall instructions regarding dilution before administration. LPN #1 stated she was later advised by her supervisor to look up administration instructions when administering a medication that was unfamiliar to her.