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	07/31/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 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 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 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.

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 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 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.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 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 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.