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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, record review, and facility policy review, the facility failed to ensure a resident's right to a comfortable and homelike environment for one (1) of (14) sampled residents (Resident #30) by failing to adequately accommodate the prolonged loss of a bathroom sink for approximately one (1) month.Findings include:A review of the facility's policy, Resident Rights, revised 1/2026, revealed, .Resident rights. The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside of the village .8. Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely .A record review of the admission Record revealed the facility admitted Resident #30 on 9/3/24 with diagnoses including Alzheimer's Disease.A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/17/26 revealed Resident #30 had a Brief Interview for Mental Status (BIMS) score of (12), which indicated her cognition was moderately impaired. Section GG revealed Resident #30 used a walker and required setup assistance with oral hygiene and toileting hygiene and supervision or touching assistance for showering and ambulation.On 5/26/26 at 2:30 PM, during an observation and interview, Resident #30 reported the facility removed the sink from her bathroom several weeks earlier and she had not received a replacement. Resident #30 explained she had been using water from the shower to wash her face and brush her teeth because she had not been provided water, a wash basin, hand sanitizer, or other hygiene alternatives in her room. Resident #30 stated she was short and had difficulty obtaining water from the shower for daily hygiene tasks.On 5/27/26 at 10:25 AM, during an observation and interview, Resident #30 reported she continued to use shower water for daily hygiene and stated she had gone almost (1) month without a sink in her room. Resident #30 stated this was her home and she should not have to go without a sink for such a prolonged period. Observation revealed no hand sanitizer, or alternative hygiene supplies available in the room.On 5/27/26 at 4:25 PM, during an interview, Certified Nurse Aide (CNA) #1 explained the sinks had been removed from resident rooms for more than three (3) weeks and (1) month. CNA #1 reported Resident #30 complained daily about the missing sink and confirmed residents were directed to use the staff bathroom or shower rooms. CNA #1 reported no additional hand sanitizer, or alternative hygiene supplies were provided to residents affected by the renovation.On 5/27/26 at 4:45 PM, during an interview, Licensed Practical Nurse (LPN) #2 confirmed the sinks had been removed for more than (3) weeks and residents were expected to use either the staff bathroom or shower rooms while awaiting replacement sinks. LPN #2 explained Resident #30 had a shower and toilet in her room but no sink.On 5/28/26 at 9:30 AM, during an interview, Housekeeping/Maintenance Staff #1 reported the sinks had been removed for almost (1) month while the facility waited for contractors and replacement sinks. Housekeeping/Maintenance Staff #1 confirmed residents were provided access to the staff bathroom and shower rooms while awaiting installation. On 5/28/26 at 9:50 AM, during an observation and interview with Resident #30 and CNA #2, Resident #30 reported she had been without a sink for almost (1) month. CNA #2 confirmed Resident #30 brushed her teeth while in the shower and confirmed no hand sanitizer had been (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provided. Observation revealed no hand sanitizer, or alternative hygiene supplies available in the room.On 5/28/26 at 10:15 AM, during an interview, Housekeeping/Maintenance Staff #2 explained the sinks had been removed from resident rooms for almost one (1) month and residents had expressed frustration regarding the prolonged loss of the sinks.On 5/28/26 at 10:30 AM, during an interview, CNA #3 explained she was not informed in advance of the sink removals and recalled obtaining water from another sink for resident care after discovering a resident room no longer had a sink. CNA #3 reported she believed some residents had received small packets of hand sanitizer but acknowledged they could not be left in resident rooms due to safety concerns.On 5/28/26 at 11:00 AM, during an interview, Resident #30 reported she had only recently been informed that a replacement sink might be installed the following week. Resident #30 stated she had not been offered water or a wash basin for daily hygiene and had been instructed to use bathrooms located outside her room if needed. Resident #30 reported she was (85) years old and should not have to leave her room to perform basic hygiene activities because her bathroom sink had been unavailable for almost (1) month.On 5/28/26 at 4:57 PM, during an interview, the Administrator reported she understood residents had experienced inconvenience related to the prolonged loss of normal in-room hygiene access and stated she hated that the renovation project had taken as long as it had.

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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 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 (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. Based on staff interview and record review, the facility failed to comply with state nursing facility staffing requirements by failing to designate a charge nurse responsible for supervision of the total nursing activities in the facility during the 3:00 PM to 11:00 PM shift, separate from the medication/treatment nurse assignment for one (1) of three (3) shifts reviewed for charge nurse supervision. Findings include:A record review of the Minimum Standards for Institutions for the Aged or Infirm for Rule 45.4.1 Nursing Facility, revealed, .To be classified as a facility, the institution shall comply with the following staffing requirements.2. Each facility shall have the following licensed personnel as a minimum.D. A registered nurse or licensed practical nurse shall serve as a charge nurse and be responsible for supervision of the total nursing activities in the facility during the 7:00 a.m. to 3:00 p.m. and 3:00 p.m. to 11:00 p.m. shift. The nurse assigned to the unit for the 11:00 p.m. to 7:00 a.m. shift may serve as both the charge nurse and medication/treatment nurse.A record review of the Facility Assessment, dated 8/7/25, revealed, Facility Assessment and Staffing Needs.This facility assessment will be used to.Consider specific staffing needs for each shift, such as day, evening, night and adjust as necessary. On 5/26/26 at 3:35 PM, during an interview with Registered Nurse (RN) #3, she explained the facility had Licensed Practical Nurses (LPNs) and RNs serving as supervisors on the day shift who worked eight (8)-hour shifts, while the medication cart nurses and Certified Nurse Aides (CNAs) worked (12)-hour shifts. RN #3 explained the facility did not have an appointed nurse serving as a supervisor or charge nurse on the evening shift as the medication cart nurses remained after the supervisors left.On 5/28/26 at 3:39 PM, during an interview with the Director of Nursing (DON) and RN #3, they explained the facility staffed three (3) medication nurses on the day shift and two (2) medication nurses on the evening shift. They explained the RN supervisors typically left the facility between 4:00 PM and 5:00 PM. The DON confirmed the facility did not designate a charge nurse responsible for supervision of the total nursing activities in the facility after the RN supervisors left the building. The DON explained there was always a nurse on call when a supervisor was not present. The DON and RN #3 stated they were not aware state regulations required a designated charge nurse responsible for supervision of nursing services during the 3:00 PM to 11:00 PM shift that was not a medication/treatment nurse.On 5/28/26 at 4:30 PM, during an interview with CNA #3, she explained she had transferred from the night shift approximately three (3) weeks earlier. CNA #3 explained the evening and night shifts did not have supervisors in the building but had medication cart nurses. CNA #3 explained if a resident issue occurred, she reported it to the medication cart nurse, who would then contact the nurse on call if needed.On 5/28/26 at 4:45 PM, during an interview with the Administrator, she explained the medication cart nurses functioned as charge nurses and staff were aware of this practice. The Administrator explained if additional supervision or assistance was needed, an on-call nurse was available to be contacted. The Administrator further explained the facility did not have a staffing policy.