MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	DB23	A. BUILDING: _____ B. WING _____	01/19/2024

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) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey and Complaint Investigation (CI), CI MS #23851, at the facility from 01/17/24 through 01/19/24. The SA investigated CI MS #23851 regarding dietary services and quality of care including food contamination, food cold, residents being left alone in dining room while eating, freezers and refrigerator temperatures not kept up to date, hot box does not work, and disposal to sink not working properly. There were no citations related to the complaint investigation. During the annual recertification survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirement and cited M635.	M 000		
M 635	45.21.7 Gastric feeding Gastric feeding. Residents who are eating alone or with assistance are not fed by a gastric tube unless their clinical condition indicates that the use of a gastric feeding tube is unavoidable. The residents who are fed by a gastric tube receive the treatment and services to prevent complications or to restore if possible, normal eating skills. This Statute is not met as evidenced by: Level II Based on observation, interviews, record review, and facility policy review, the facility failed to date and label a tube feeding bag for one (1) of (1) residents reviewed for tube feeding management. (Resident #4) Findings include:	M 635	1. Resident #4 was evaluated by the Assistant Director of Nurses (ADON) on 1/17/2024 to ensure no distress or negative side effects due to failing to date, time and label the tube feeding bag and water bag. The Licensed Practical Nurse (LPN) who failed to date, time and label the tube feeding bag and water bag was counseled by the Registered Nurse on 1/18/2024.	2/27/24

Mississippi State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/08/24

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M 635	Continued From page 1 A review of the facility's policy "Care and Treatment of Feeding Tubes", undated, revealed, "Policy: It is a policy of this village to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible ..." On 01/17/24 at 12:36 PM, during an observation, Resident #4 was lying in bed with the head of the bed elevated. There was a tube feeding running at 70 cc (cubic centimeters)/hour (hr). The tube feeding formula bag did not contain a date, time, or label indicating when the bag of tube feeding was started. The bag had a manufacturer's label indicating the type of feeding as Isosource. There was a bag of water that did not contain a date, time, or label indicating when the water flush was started. On 01/17/24 at 4:16 PM, during an observation and interview with Licensed Practical Nurse (LPN) #6, she confirmed that the feeding and water did not contain a date, time, or label indicating when the bag of tube feeding or water was started. She stated that the bags should include a label with the date and time so staff will know how long the tube feeding has been flowing and to ensure a resident does not receive old formula. LPN #6 said that it was the facility's policy to label the tube feeding daily when a new bag was hung. On 01/19/24 at 04:05 PM, during an interview with the Director of Nursing (DON), she explained she expected staff to follow standard procedures for labeling tube feeding and all nurses had been educated on proper labeling. A record review of "Admission Record" revealed the facility admitted Resident #4 on 02/07/23 with	M 635	2. Any resident who is fed by enteral means can be affected by failing to date, time and label the tube feeding bag and water bag. 3. All licensed nurses were inserviced by the Director of Nurses (DON) beginning on 1/30/2024 with completion by 2/8/2024 regarding Care and Treatment of Feeding Tubes. 4. Spot checks to be completed by a Licensed Nurse Supervisor two times a week for four weeks to ensure the tube feeding bag and water bag is dated, timed and labeled beginning 1/30/2024 with completion on 2/27/2024. All weekly spot checks to be reported to the Director of Nurses. The findings of the spot checks to be reviewed by the DON weekly and presented to the Quality Assessment and Assurance (QAA) team on 2/27/2024 and monthly thereafter to determine if further action is needed. All nurses upon hire will be inserviced on proper tube feeding management.	

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M 635	Continued From page 2 a diagnoses that included Acute Respiratory Failure with Hypoxia and Gastrostomy Complication. A record review of the Quarterly Minimum Data Set with an Assessment Reference Date of 12/05/23 revealed Resident #4 was coded as having a feeding tube. A record review of the "Order Summary Report", with active orders as of 01/18/2024, revealed Resident #4 had a Physician's Order, dated 8/31/23 for "Enteral Feed Order ...Continuous Feed: Isosource 1.5 to 70 ml (milliliter)/hr."	M 635		