

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13DM	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/11/2024
NAME OF PROVIDER OR SUPPLIER DUGAN MEMORIAL HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 26894 EAST MAIN STREET WEST POINT, MS 39773		
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M 000	Initial Comments The State Agency (SA) conducted a complaint investigation (CI) MS#24913 regarding administration and CI MS#25247 regarding verbal abuse on 6/11/24. During the investigation, the SA determined that the facility was not in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm, and identified non-compliance at M500 for CI MS #25247 for verbal abuse. There were no deficiencies cited for CI MS #24913 regarding administration. The census at the time of the survey was 51 with a bed capacity of 60 beds.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or	M 500		7/18/24

Mississippi State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

06/21/24

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M 500	Continued From page 1 nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident 's choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;	M 500		

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M 500	Continued From page 2 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately	M 500		

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M 500	Continued From page 3 with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II Based on resident and staff interview, record	M 500	"A thorough investigation was conducted by the Director of Nursing Services and	

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M 500	Continued From page 4 review and facility policy review, the facility failed to prevent verbal abuse to a resident from a staff member for one (1) of three (3) residents reviewed for abuse. Resident #1 Findings Include Review of the facility policy titled, "Abuse, Neglect and Exploitation-2019" with a review date of 2019 revealed under, "Policy ...It is the policy of this facility to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property". This review revealed under, "IV. Identification of Abuse, Neglect and Exploitation ...B. 5. Verbal abuse of a resident overheard". An interview on 6/11/24 at 8:05 AM with the Administrator revealed she was notified on 5/26/24 by the Director of Nurses (DON) that Certified Nurse Assistant (CNA) #1 had been witnessed by CNA #2 and CNA #3 "talking ugly" to Resident #1 and was sent home that day pending an investigation. She stated that she investigated the incident and could not determine that it was verbal abuse, because of different stories from the witnesses and the resident. She stated that CNA #1 had issues with being disrespectful to co-workers and attendance issues and they determined that despite not substantiating that this incident was verbal abuse it was disrespectful to the resident, and she was terminated. She confirmed that telling a resident to stay off of their call light or threatening a resident would be considered verbal abuse and that all staff are in-serviced on abuse on hire. An interview on 6/11/24 at 9:27 AM with the DON	M 500	the Facility Administrator regarding the allegations made by resident #1. Results of the investigation were reported to the State Survey Agency. CNA# 1 was suspended immediately on 5/26/2024 pending investigation. CNA# 1 employment was terminated on 5/30/2024. "The facility has determined that all residents have the potential to be affected. "On 5/27/2024 an Inservice began on verbal abuse by Administrator and Director of Nursing, Inservice was completed on 6/21/2024 and included all staff. "The Director of Nursing will conduct weekly interviews with three (3) cognitive residents for four (4) weeks beginning 6/18/2024 and then monthly beginning 7/15/2024 until 9/10/2024. The interview reports will be assessed weekly by the interdisciplinary team and reported at the monthly quality assurance and performance improvement meeting on 7/9/2024 and monthly thereafter for three (3) months to ensure compliance.	

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M 500	Continued From page 5 confirmed that Registered Nurse (RN) #1 called her on the morning of 5/26/24 to inform her that CNA #1 had been witnessed talking ugly to Resident #1 by CNA #2 and CNA #3. She revealed that she interviewed CNA #2 and CNA #3 over the phone with RN #1 present and they told her that CNA #1 had yelled at Resident #1 to stay off of his call light because she was shorthanded. She revealed that at that time she told RN #1 to immediately send CNA #1 home until the investigate was complete and to not return until they called her on Monday 5/28/24. An interview on 6/11/24 at 10:36 AM with CNA #1 confirmed that she had been terminated by the facility for "some interaction with resident," (Resident #1.) She denied saying anything inappropriate to Resident #1 but admitted to telling the resident that he had just used his call light to have his remote and cell phone given to him, which was right in front of him on his overbed table. She stated that she was not sure if she had attended any in-services at the facility about abuse, but she knew not to abuse a resident. She admitted to working two jobs but stated that it did not affect her work here at the facility. She admitted that her partner had called in that day, so she had to work alone with about 12 residents. An interview on 6/11/24 at 10:45 AM with CNA #2 confirmed she was sitting out in the hall not far from Resident #1's room and CNA #1 was standing outside of his door yelling at him for pushing his call light again. She stated that she overheard CNA #1 tell the resident "I'm not having it today, I'm shorthanded; keep it up and I'm gonna take that cell phone." She revealed that she thinks CNA #1 took the residents call light away from him. She admitted that she had	M 500		

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M 500	Continued From page 6 worked with CNA #1 about 6 months, and she had a bit of an attitude, but she had never heard her talk to any residents that way. She stated that CNA #1's partner had called in that morning, and she thought she was frustrated about that, but that her and CNA #3 had offered to help, but she had refused. An interview on 6/11/24 at 11:00 AM with CNA #3 confirmed that she was in the hall and heard CNA #1 yell at Resident #1 saying, "Did I not tell you to not be on that d _ _ _ light, I'm the only one here today," which was not true. Her partner had called in, but CNA #2 and I were there and had offered to help her, but she refused. She stated that shortly after this incident that RN #1 walked down the hall toward them and ask why Resident #1 was calling her from his cell phone and that is when we told her what had happened. She stated she had heard CNA #1 talk smart to residents before, but not to this extent. An observation on 6/11/24 at 11:08 AM of the camera footage during the time of the alleged verbal abuse with Resident #1 on 5/26/24 at approximately 9:35 AM revealed CNA #1 went into Resident #1's room around 9:35 AM and CNA #2 was sitting in the hall and CNA #3 walked out of the laundry room and stopped in the hall for a brief moment as CNA #1 came out of Resident #1 room and stood outside his door facing into the room. The video footage showed that the two CNA's were in hearing distance of Resident #1's room when CNA #1 went into the room. An observation on 6/11/24 at 11:10 AM of the area that CNA #2 and CNA #3 were standing in relation to Resident #1's room according to the camera footage was approximately 20 feet.	M 500		

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M 500	Continued From page 7 An interview on 6/11/24 at 11:18 AM with RN #1 confirmed that CNA #2 and CNA #3 reported to her on the morning of 5/26/24 that CNA #1 had told Resident #1 that he did not need to be on his call light because she was busy. She stated that she talked with Resident #1, and he told her that CNA #1 had told him that if he did not stay off of his call light that she was going to put him in his chair. She revealed she notified the DON and was told to send CNA #1 home, so she did after telling her it was concerns about how she was talking to Resident #1. An interview on 6/11/24 at 11:30 AM with Resident #1 confirmed that CNA #1 had taken his call light and put it behind his bed because she said he was using it too much, so he used his cell phone and called the facility. He stated that (CNA #1's proper name) told him if he did not stay off of his call light, she was going to put him in his chair. He revealed he did not think she was yelling but was talking loudly and it did not upset him because he still had his phone and was able to call the facility to ask for help in his room. He revealed this was not the first time she had talked to him that way but admitted that he had never reported it to anyone. Record review of the facilities in-services on abuse revealed an in-service was held 2/21/24 but was not attended by CNA #1. Record review of CNA #1's new hire information revealed she was hired at the facility on 11/17/23 and signed acknowledgement of the "Vulnerable Adults Act" on 11/17/23. Record review of CNA #1's timesheet revealed she came in on 5/26/24 at 6:38 AM and left at 10:48 AM.	M 500		

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M 500	Continued From page 8 Record review of Resident #1's "Admission Record" revealed the resident was admitted to the facility on 3/7/18 with medical diagnoses that included Infarction and Aspergers Syndrome. Record review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/15/24 revealed in Section C a Brief Interview of Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. Record review of Resident #1's care plan revealed the resident had a care plan regarding the need for assistance with ADL's (Activities of Daily Living), he has a past history of CVA (Cerebral Vascular Accident). He is able to do more for himself but wishes for staff to perform most of his care with an intervention to keep call light in easy reach and answer promptly.	M 500		