STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255313	A. BUILDING _____ B. WING _____	C 06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUGAN MEMORIAL HOME	26894 EAST MAIN STREET WEST POINT, MS 39773

(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) COMPLETION DATE
F 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 requirements of participation in Medicare and Medicaid Services. The SA identified non-compliance and cited F600 for CI MS #25247 for verbal abuse from a staff member toward a resident. 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.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, record review and facility policy review, the facility failed to prevent verbal abuse to a resident from a staff	F 600	•A thorough investigation was conducted by the Director of Nursing Services and the Facility Administrator regarding the	7/18/24

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

Electronically Signed | 06/21/2024

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F 600	Continued From page 1 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, "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 confirmed that Registered Nurse (RN) #1 called	F 600	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# 1employment 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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F 600	Continued From page 2	F 600		

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 investigation 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

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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 _ _ n 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 RN #1 walked down the hall toward them and asked 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.

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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

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F 600	Continued From page 5 she came in on 5/26/24 at 6:38 AM and left at 10:48 AM. 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 for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact.	F 600		