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	255313	A. BUILDING _____ B. WING _____	09/26/2024

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 an annual recertification survey at the facility from 9/24/24 through 9/26/24. During the survey, the SA determined that the facility was not in compliance with Medicare and Medicaid requirements of participation and cited F580 for notification of provider, F656 for implementation of care plan, and F880 for infection control. The census at the time of the survey was 50 with a license for 60 beds.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2)	F 580		11/12/24

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

Electronically Signed | 10/08/2024

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F 580	Continued From page 1 is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to ensure the medical provider was notified of a resident refusing multiple doses of prescribed antibiotics for one (1) of six (6) residents reviewed for medication use. Resident #21 Findings include: Record review of facility policy titled "Medication Administration" dated 1/24, revealed, "Medications are administered by licensed nurses, or other staff who are legally authorized	F 580	•On 9/26/2024 the provider and Residents responsible party for resident #21 were notified on residents refusal of medication. •All residents have the potential to be affected. •Inservice began on 9/30/2024, by the Director of Nursing for all nurses on residents' refusal of medication and appropriate steps following a resident's refusal of medication. •Beginning 10/1/2024, all resident refusals will be reviewed in daily meetings Monday	

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F 580	Continued From page 2 to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection ...18. Report and document any adverse side effects or refusals ..." During an interview on 9/25/24 at 3:50 PM, Registered Nurse (RN) #2 revealed Resident #21 had recently been in the hospital and diagnosed with pneumonia and was on antibiotics. She revealed the resident would often refuse her medications and that if a resident refused medications, the nurse was to notify the provider and the resident's representative. On 9/25/24 at 4:10 PM, an interview with the Director of Nursing (DON) revealed Resident #21 refused several doses of the antibiotic medication ordered for the treatment of pneumonia and the provider was not notified. She confirmed it was important to notify the provider so that appropriate care could be ordered. She confirmed the facility failed to notify the provider of the antibiotic medications refused by this resident. During a phone interview on 9/25/24 at 4:30 PM, the Nurse Practitioner stated she was in the facility last week and was aware the resident refused to take her medications for a few days but thought she had restarted taking them. She stated she was unaware that the resident refused her antibiotics which included the past two doses that would have completed her 10-day course of antibiotics. She stated it was important for the provider to be notified of refusals of medications so treatment could be reevaluated, and the treatment course could be changed to ensure the resident received appropriate care. She also	F 580	through Friday by the interdisciplinary team permanently. If any refusals are identified, the Interdisciplinary team will check for appropriate documentation of provider and resident's responsible party. The Quality Assurance and Performance Improvement Plan Committee will meet monthly beginning 10/8/2024 and review for three months and will track and trend any noncompliance and make recommendations that may include further training or corrective actions for employees.	

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F 580	Continued From page 3	F 580		

stated that not receiving ordered antibiotic medications could lead to an infection not being treated effectively.

An interview with the Administrator on 9/26/24 at 8:20 AM, confirmed the facility failed to notify the provider that a resident refused multiple doses of an antibiotic ordered for pneumonia. She confirmed that notifying the provider was necessary so an alternate treatment could be ordered if the provider chose that option.

During an interview on 9/26/24 at 12:10 PM, RN #2 stated she was not notified that Resident #21's antibiotic medication was not administered due to the resident refusing. She stated that typically the Licensed Practical Nurse (LPN) would notify the RN and the RN would notify the provider and enter any new orders that were given by the provider. She confirmed that since she was unaware of the resident refusing her last two doses of her antibiotics, the provider was not notified.

A phone interview with LPN #1 on 9/26/24 at 12:15 PM, revealed she attempted to give Resident #21 her antibiotics on several different days and would attempt several times each day, but the resident refused each time. She stated during the previous week, she had notified RN #1 of the refusals, but on 9/23/24 and 9/24/24, she did not notify RN #2 of the refusals. She admitted she did not see RN #2 immediately after the refusals and she just forgot. She stated she did document the refusals in the Electronic Medication Administration Record (EMAR), but for the dates of 9/23/24 and 9/24/24, she did not notify the RN. She stated she had been in-serviced on medication administration and was

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aware of the process for notification to the RN if the resident refused medications and the RN would notify the provider.

During a phone interview on 9/26/24 at 12:25 PM, RN #1 stated she had notified the provider of the resident's refusals of medications last week. She stated the process for refusals are for the LPN to inform the RN and the RN would notify the provider.

During an interview on 9/26/24 at 12:45 PM, the DON confirmed the facility failed to notify the provider of the resident's refusal of her antibiotics. She confirmed a resident not receiving antibiotics as ordered could lead to the infection not being treated properly. She stated LPN #1 had been in-serviced on medication administration and should have notified the RN so the RN could have notified the provider.

Record review of "Progress Note" of Registered Nurse (RN) #2 dated 9/13/24, revealed, "Notified by Cart Nurse that resident was having chest pain. Asked resident if she (by pointing and verbally asking) resident was she having chest pain and resident nodded, 'yes'. ... Notified (proper name removed) Nurse Practitioner (NP), NP gave orders to send out the the ER (Emergency Room)."

Record review of "Order Summary Report" revealed an order dated 9/13/24 to "send resident to ER for c/o (complaints of) chest pain".

Record review of hospital "Emergency Department Note" dated 9/14/24, revealed a diagnosis of Pneumonia of left lower lobe due to infectious organism.

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F 580	Continued From page 5 Record review of nursing "Progress Note" dated 9/14/24, revealed, "Elder returned from hospital per ambulance. Alert and oriented with eyes opened. ... Report received from ER. Elder x-ray showed pneumonia ... Prescription given for Elder's condition." Record review of Resident #21's "Order Summary Report" revealed an order dated 9/14/24 for Cefdinir Oral Suspension 250 mg (milligrams)/5 ml (milliliters) give 12 ml by mouth in the morning for pneumonia for 10 days with start date of 9/15/24 and end date of 9/25/24. Record review of Resident #21's Electronic Medication Administration Record (EMAR) revealed on 9/23/24 and 9/24/24, the resident did not receive the ordered antibiotic with the reason documented as "Drug Refused". Record review of Resident #21's "Admission Record" revealed the facility admitted the resident on 5/6/2016 with diagnoses that included Shortness of breath and Dementia. Record review of Resident #21's quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 8/27/24, revealed "Should Brief Interview for Mental Status be conducted?" Response to this was, "No (resident is rarely/never understood).	F 580		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered	F 656		11/12/24

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F 656	Continued From page 6	F 656		

care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged

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F 656	Continued From page 7 by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review, and facility policy review, the facility failed to implement a care plan for one (1) of 18 sampled residents' care plans. Resident #21 Findings Include: Record review of facility's policy titled, "Comprehensive Care Plans" dated 10/22, revealed "It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that include measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment". Record review of Resident #21's care plan revealed a focus area dated 9/15/24 of "Elder has pneumonia". Interventions listed included administer medications as ordered, Cefdinir for ten days for pneumonia, and to keep informed of changes and update MD as needed. An interview with the Director of Nursing (DON) on 9/25/24 at 4:10 PM, revealed Resident #21 refused several doses of the antibiotic medication ordered for the treatment of pneumonia and the provider was not notified. She stated the care plan gives information to care for the resident's needs and she confirmed the care plan for antibiotic medication administration as ordered for treatment for pneumonia and to "keep	F 656	•On 9/25/2024, Licensed Practical Nurse #1 was in serviced on the facility comprehensive care plan policy by the Director of Nursing. •All residents have the potential to be affected. •On 9/30/2024, An Inservice began for all staff, by the Director of Nursing on following the residents care plan when they refuse medications. •On 9/30/2024, all resident refusals will be reviewed in daily meetings Monday through Friday by the interdisciplinary team permanently. If any refusals are identified, the Interdisciplinary team will check to ensure the care plan is being followed. The Quality Assurance and Performance Improvement Plan Committee will meet monthly beginning 10/8/2024 and review for three months and will track and trend any noncompliance and make recommendations that may include further training or corrective actions for employees.	

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F 656	Continued From page 8	F 656		

informed of changes and update RP (Resident's Representative) and MD (Medical Doctor) as needed", was developed but was not followed.

During an interview on 9/26/24 at 10:30 AM, the Minimum Data Set (MDS) Coordinator revealed she is one of the facility staff members responsible for developing the care plans for the residents. She stated the care plan is to inform staff of the needs of the residents and the care needed for the resident and should be followed to ensure the care is appropriate. She stated the care plan for Resident #21's diagnosis of pneumonia was developed and included the interventions to administer the medications as ordered, antibiotics each morning for 10 days for pneumonia, and to update Medical Doctor as needed and keep informed of changes. She confirmed the care plan was not implemented.

Record review of Resident #21's "Order Summary Report" revealed an order dated 9/14/24 for Cefdinir Oral Suspension 250 mg (milligrams)/5 ml (milliliters) give 12 ml by mouth in the morning for pneumonia for 10 days with start date of 9/15/24 and end date of 9/25/24.

Record review of Resident #21's Electronic Medication Administration Record (EMAR) revealed on 9/23/24 and 9/24/24, the resident did not receive the ordered antibiotic with the reason documented as "Drug Refused".

Record review of Resident #21's "Admission Record" revealed the facility admitted the resident on 5/6/2016 with diagnoses that included Shortness of breath and Dementia.

Record review of Resident #21's quarterly

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F 656	Continued From page 9 Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 8/27/24, revealed "Should Brief Interview for Mental Status be conducted?" Response to this was, "No (resident is rarely/never understood).	F 656		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 880		11/12/24

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F 880	Continued From page 10 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review the facility failed to initiate contact isolation precautions for a resident with Methicillin-resistant Staphylococcus Aureus	F 880	•On 9/25/2024, wound care on residents #19 was redone following appropriate wound care technique by the Registered Nurse supervisor. On 9/25/2024,	

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F 880	Continued From page 11 (MRSA) and failed to prevent the possibility of the spread of infection by not utilizing proper hand hygiene for one (1) of four (4) resident care observations. Resident #19. Findings Include: Review of the facility policy "Clean Dressing Change" dated 10/2022 revealed, "It is the policy of this facility to provide wound care in a manner to decrease potential for infection and/or cross-contamination." Review of the undated facility policy "Transmission-Based Precautions" revealed, "It is our policy to take appropriate precautions to prevent transmission of infectious agents.....Contact Precautions - Intended to prevent transmission of infectious agents, including epidemiologically important microorganisms, which are spread by direct or indirect contact with the resident or the resident's environment..." On 09/24/24 at 1:00 PM, on entrance into the facility, a brief interview with Administrator (ADM), revealed that there were no residents on Transmission Based Precautions (TBP). On 09/24/24 at 2:30 PM, an interview with Resident #19 revealed that he had two wounds on his bottom, that the nurses were cleaning them and changing the dressings every day. On 09/25/24 at 10:40 AM, an observation revealed Licensed Practical Nurse (LPN) #1, completed wound care to Resident #19's pressure ulcers to his sacrum and left buttock using enhanced barrier precautions (EBP). LPN	F 880	transmission-based precautions signage was posted on resident #19 door by the Infection Control Nurse. •All residents with wounds and all residents needing transmission-based precautions have the potential to be affected. •On 9/25/2024, Licensed Practical Nurse #1 was in-serviced on proper wound care techniques by the Director of Nursing. Beginning 10/1/2024, all nurses were educated on the wound care and transmission-based precautions policy by the Director of Nursing and/or Infection Control Nurse. Beginning 10/1/2024, new orders are being reviewed by an interdisciplinary team member and discussed in the daily morning meetings in order to identify the need for transmission-based precautions permanently. An audit was performed on 9/26/2024 by the Infection Control Nurse to identify any other residents in need of transmission based precautions. Wound care check offs began 10/7/2024 by registered Nurse or Director of Nursing. •The Director of Nursing or Registered Nurse will observe wound care on two residents per week for four weeks beginning 10/7/2024 and two residents per month for three months to ensure compliance. The Quality Assurance and Performance Improvement Plan Committee will review wound care checks to identify any areas of concern. The Quality Assurance and Performance Improvement Plan Committee will meet monthly beginning 10/8/2024 for three months and track and trend any	

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F 880	Continued From page 12 #1 washed her hands and donned a gown and gloves. She removed the old dressing and then cleaned the sacral wound and cleaned the wound to his left buttock with normal saline without changing her gloves. LPN #1 changed gloves after cleaning both wounds, applied the ordered treatment to both wound beds and covered the wounds with bordered foam dressings. LPN #1 did not perform hand hygiene between glove changes, and she used the same gloves to clean both wounds. LPN #1 removed her gown and gloves, disposed of them in a trash can designated for Personal Protective Equipment (PPE) just inside the resident's door, and she washed her hands. There was no "Contact Precaution" signage observed on Resident #19's room door and there were no biohazard containers in his room. On 09/25/24 at 10:50 AM, an interview with LPN #1, revealed that Resident #19 had the wounds to his sacrum and left buttocks for several months and they were improving. She revealed that they used enhanced barrier precautions with any resident with wounds to protect the residents as well as themselves. LPN #1 confirmed that she did not change her gloves after removing the soiled dressing before cleaning both of the wound areas and also failed to change gloves between the two different wound care areas. She also confirmed that she had cleaned both wounds using the same gloves and agreed that she should have completed wound care on one wound before going to the next to prevent cross contamination. In an interview on 09/25/24 at 10:55 AM, LPN #1 revealed that she "Just remembered" that Resident #19 was diagnosed with MRSA	F 880	noncompliance and make recommendations that may include further training or corrective actions for employees. The Quality Assurance and Performance Improvement Plan Committee will meet monthly to discuss residents on transmission-based precautions beginning 10/8/2024 for three months and track and trend any noncompliance and make recommendations that may include further training or corrective actions for employees.	

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 _____	09/26/2024

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

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F 880	Continued From page 13	F 880		

(Methicillin-Resistant Staphylococcus Aureus) to one of the wounds a couple weeks ago and she was "Pretty sure he still had it." She also confirmed that any resident with MRSA should be on contact isolation precautions to prevent the spread of infection.

On 09/25/24 at 11:00 AM, an interview with Infection Control Nurse (ICN) revealed that Resident #19 was on EBP because of his wounds. She revealed that Resident #19 had a wound culture a couple weeks ago and was on antibiotics. ICN pulled up Resident #19's wound culture results on his Electronic Medical Record (EMR) and confirmed the positive MRSA results and stated, "I was not aware that he had MRSA, I didn't catch that." She revealed that Resident #19 should be on contact isolation precautions to prevent the spread of infection and that she would take care of that now. ICN revealed that contact precaution signage should be on the door and that there should be PPE outside the resident's door and they should have red barrels placed inside his room for staff to dispose of their used PPE. She revealed that they reviewed all antibiotics in their Quality Assurance (QA) meetings every month and went over antibiotics and infections weekly in their high-risk meetings. ICN revealed that it was important to follow the correct guidelines when doing wound care on a resident with MRSA to prevent the spread of infection.

On 09/26/24 at 9:10 AM, an interview with Certified Nursing Assistant (CNA) #1, revealed that she had heard a couple weeks ago that Resident #19 had MRSA to one of his wounds. She revealed that she was already wearing masks, gloves and gowns and was not told to

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F 880	Continued From page 14	F 880		

treat him any differently. She revealed that the ICN placed the contact precaution sign on his door and red barrels in the room yesterday. CNA #1 revealed that usually when a resident was placed on contact precautions, they had in-services, and the nurses let them know. She revealed that it must have been a miscommunication problem.

On 09/26/24 at 12:22 PM, a phone interview with Registered Nurse (RN) #1, revealed that Resident #19 had wounds and that the wound center had called in positive MRSA culture results to her a couple weeks ago. RN #1 revealed that Resident #19 was currently taking two antibiotics for the MRSA and was ordered to take it for thirty days. She revealed that this resident should be on contact precautions to prevent the spread of infection in the facility.

On 09/26/24 at 1:15 PM, an interview with Director of Nursing (DON) and Administrator (ADM), revealed that the person who took the call about the positive culture results, should have initiated the Contact Isolation Precautions for Resident #19. She revealed that it was everyone's responsibility who knew about the infection to get it initiated. She revealed if they had staff members in the room caring for a resident who they knew had MRSA, the staff should look at protecting the resident and ensuring that measures were in place to prevent the spread of infection.

Record review of Resident #19's "Wound Culture" revealed that the culture of his left buttock pressure ulcer was collected on 08/30/24 and final MRSA results were received on 09/02/24.

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F 880	Continued From page 15	F 880		

Record review of Resident #19's "Admission Record" revealed an admission date of 09/01/2015 and had diagnoses that included Hemiplegia and Hemiparesis following Unspecified Cerebrovascular Disease, Stage 2 Pressure Ulcer of Sacral Region, and Stage 4 Pressure Ulcer of Left Buttock.

Record review of Resident #19's Order Summary Report revealed an order with start date of 09/04/24 for "Amoxicillin Oral Capsule 500 MG (milligrams)... Give 1 capsule by mouth three times a day for MRSA for 30 Days" and "Bactrim DS Oral Tablet 800-160 MG...Give 1 tablet by mouth two times a day for MRSA for 30 Days."

Record review of Resident #19's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 09/12/24 under Section C revealed a Brief Interview for Mental Status (BIMS) score of 13 which indicated that he was cognitively intact.

Record review of Resident #19's "Progress Note" dated 09/03/24 revealed new order for antibiotics related to MRSA infection in wound and was signed by RN #1.