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
	13DM	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) COMPLETE DATE
M 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 the Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm and cited M1570 for infection control. The census at the time of the survey was 50 with a license for 60 beds.	M 000		
M1570	48.58.1 Infection Control The following infection control standards shall be met: 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases. 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions.	M1570		11/12/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13DM	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) COMPLETE DATE
M1570	Continued From page 1 This Statute is not met as evidenced by: Level II 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 (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	M1570	•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, 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13DM	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) COMPLETE DATE
M1570	Continued From page 2 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 #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	M1570	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 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
	13DM	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) COMPLETE DATE
M1570	Continued From page 3	M1570		

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 (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13DM	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) COMPLETE DATE
M1570	Continued From page 4	M1570		

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 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"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13DM	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) COMPLETE DATE
M1570	Continued From page 5 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. 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.	M1570		