

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/08/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255313	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/16/2025
NAME OF PROVIDER OR SUPPLIER DUGAN MEMORIAL HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 two (2) Complaint Investigations (CI MS #28691 and CI MS #29222) at the facility on 6/16/25. During the investigation, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid. CI MS #29222 was investigated for resident-on-resident sexual abuse and cited F600 at a G level. The SA investigated CI MS #28691 and no deficiencies were cited related to that CI.	F 000			
F 600 SS=G	The census at the time of the survey was 60 with a bed licensure for 60 beds. 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 staff interview, observation of video camera footage, record review, and facility policy review, the facility failed to ensure a resident's right to be free from sexual abuse by another	F 600	1.Resident #2 was immediately removed from the common area and placed on one on one with a staff member until Resident #2 was transported by staff members to		7/7/25

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

TITLE

(X6) DATE

Electronically Signed

06/25/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/08/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255313	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/16/2025
NAME OF PROVIDER OR SUPPLIER DUGAN MEMORIAL HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 600	Continued From page 1 resident for one (1) of four (4) residents sampled. (Resident #1) Specifically, the facility failed to prevent Resident #2, a cognitively intact resident with mental health diagnoses, from engaging in non-consensual sexual contact with Resident #1, a severely cognitively impaired resident, in a supervised common area of the facility. This failure resulted in actual harm to Resident #1, as she experienced inappropriate sexual contact without the ability to consent, resist, or report the incident. Findings include: Record review of facility policy titled, "Abuse, Neglect, and Exploitation", dated 11/2017, revealed, "It is the policy of this facility to provide protections 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. ... Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. ... Sexual abuse is non-consensual sexual contact of any type with a resident". During an interview on 6/16/25 at 10:40 AM, the Administrator stated an incident occurred on 6/6/25 around 6:15 PM where Resident #2 was discovered by a visitor with his hand underneath Resident #1's blanket in the common area of the facility. The visitor immediately reported it to Certified Nursing Assistant (CNA) #1 and as she approached the residents, Resident #2 stopped what he was doing and wheeled himself back to his room. CNA #1 immediately reported this to Licensed Practical Nurse (LPN) #1, and when	F 600	behavioral health hospital around 10:30pm on 6/6/2025. On 6/6/2025, the Administrator reached out to the local police department to file a report. The Police Department let the Administrator know that a report would have to be filed in person. The Police report was filed on 6/9/2025. Resident #1 was assessed by the RN supervisor on 6/7/2025 with no findings of trauma noted. The Nurse practitioner assessed resident #1 on 6/9/2025, no findings of trauma were noted. A Quality Assurance Performance Improvement Meeting was held on 6/6/2025. 2. All residents have the potential to be affected. 3. On 6/6/2025, an inservice was initiated by the Administrator and Charge Nurse on the facility's abuse policy; inservice was continued by Administrator and Director of Nursing on subsequent shifts. On 6/7/2025, the Director of Nursing interviewed other cognitive elders to determine if any other instance of abuse took place. No other incident was revealed. When resident #2 returned to the facility on 6/20/2025, he was placed one on one with a staff member and monitoring began. Resident #2 left for the ER on 6/23/25 and remains out of the facility as of 6/26/25. Cognitively impaired residents were assessed for injuries by RN supervisor beginning 6/16/25 for any signs of abuse and completed on 6/17/25. 4. Resident #2 will be accompanied by a staff member twenty-four hours a day, seven days a week while his movements are tracked and his behavior is observed.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/08/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255313	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/16/2025
NAME OF PROVIDER OR SUPPLIER DUGAN MEMORIAL HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 600	Continued From page 2 they went to check on Resident #2 he had returned and was attempting to raise her blanket again and LPN #2 stopped him and he returned to his room again. Resident #2 was immediately placed on 1:1 observation and an investigation began. She revealed that when this incident first occurred, the staff were unaware of the full extent of what was being done due to the positioning of the residents, the staff, the wheelchairs, and the wall, but the camera's position allowed the full extent of the incident to be seen with an unobstructed view. When the video footage was viewed, the Administrator acknowledged that the extent of the touching was realized, and she noted how disturbing it was. She stated during the video review you could see that Resident #1 was sitting in the rotunda area and Resident #2 approached in his wheelchair and sat next to her. During the first part of their interaction, it appeared that they were talking to each other, then Resident #2 raised the blanket and rubbed the back of the resident's right thigh and then moved his hand up to her private area. She was notified at that time and Resident #2 was placed on one-on-one observation and a consult for behavioral health was obtained and he was transferred out later that evening. Observation of incident on the facility's video on 6/16/25 at 11:00 AM, the video revealed Resident #1 in her geriatric-type chair in the rotunda which was a common area in the facility. She appeared to be alert and moving her arms to her face and back to her lap and moving her legs slightly. Resident #2 was in his wheelchair and rolled up to her left side at 6:15 PM. Resident #2 appeared to be speaking to Resident #1. Being in the geriatric chair, Resident #1 had her left leg extended and her right leg positioned where her	F 600	One on one monitoring will continue indefinitely until alternate placement can be found for resident #2. Findings from observations will be discussed in Quality Assurance Performance Improvement Meeting monthly beginning July 7th and every month following for three months.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/08/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255313	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/16/2025
NAME OF PROVIDER OR SUPPLIER DUGAN MEMORIAL HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 600	Continued From page 3 knee was raised with her foot resting flat on the reclining part of the chair. At 6:17 PM, Resident #2 lifted Resident #1's blanket, at 6:18 PM, Resident #2 uses his left hand and rubs the back of her lower thigh and moved his hand up towards her genital area on the back side of her thigh. He switched to his right hand and began a repetitive movement with his hand at Resident 1's vaginal area. Video footage revealed that this interaction continued for almost three (3) minutes until CNA #1 intervened at 6:21 PM. From the view of the approaching CNA, it would have been difficult to see what was occurring since she was approaching from behind Resident #2 and next to a wall. The camera view was straight towards the residents so the view and ability to see what occurred was not obstructed and when CNA #1 approached, Resident #2 left the area. During an interview on 6/16/25 at 4:20 PM, the Administrator acknowledged each resident had the right to be free from abuse and she confirmed the facility failed to ensure a resident was free from sexual abuse by another resident. Record review revealed that Resident #2 was placed on 1:1 observation and was sent out to a geri-psych facility later that night and remains there at the present time. Record review of Resident #1's "Admission Record" revealed she was admitted to the facility on 2/5/25 with diagnoses that included Alzheimer's Disease, Dementia, and Anxiety Disorder. Record review of Resident #1's quarterly Minimum Data Set (MDS) Section C dated 5/6/25 revealed Resident #1 was rarely/never	F 600			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/08/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255313	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/16/2025
NAME OF PROVIDER OR SUPPLIER DUGAN MEMORIAL HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 600	Continued From page 4 understood and a Brief Interview for Mental Status (BIMS) was not able to be obtained, which indicated the resident had severe cognitive impairment. Record review of Resident #2's "Admission Record" revealed resident was admitted to the facility on 10/8/24 with diagnosis that included Bipolar Disorder and Schizophrenia. Record review of MDS Section C dated 4/22/25 revealed a BIMS score of 13 which indicated the resident was intact cognitively.	F 600			