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 _____	C 06/16/2025

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 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 Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm. CI MS #29222 was investigated for resident-on-resident sexual abuse and cited M 500. The SA investigated CI MS #28691 and no deficiencies were cited related to that CI. The census at the time of the survey was 60 with a bed licensure for 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		7/7/25

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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 III	M 500	1.Resident #2 was immediately removed from the common area and placed on one	

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M 500	Continued From page 4 Based on staff interview, observations, record review, and facility policy review, the facility failed to ensure a resident was free from sexual abuse by another 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	M 500	on one with a staff member until Resident #2 was transported by staff members to 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	

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M 500	Continued From page 5 his room. CNA #1 immediately reported this to Licensed Practical Nurse (LPN) #1, and when 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	M 500	are tracked and his behavior is observed. 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.	

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M 500	Continued From page 6	M 500		

extended and her right leg positioned where her 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

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M 500	Continued From page 7 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.	M 500		