

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13DM	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/12/2019
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) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted a complaint investigation CI MS# 16414 on 12/12/2019. Concerns identified in the complaint were related to possible abuse of Resident #3. The specific concern was CNA #1 had abused the resident. This concern was not substantiated and no deficiencies were cited. During the survey, the SA determined the facility was in substantial compliance with requirements of participation in Medicare and Medicaid. The facility had a census of 58 at the time of the complaint survey with a bed capacity of 60.	M 000		

Mississippi State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE