

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

PRINTED: 07/28/2023  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            |                                                                                                                          |  |                                                        |
|----------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255313</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01 - MAIN BUILDING</b><br><br>B. WING _____                                 |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/12/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>DUGAN MEMORIAL HOME</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>26894 EAST MAIN STREET<br/>WEST POINT, MS 39773</b>                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                       | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                             |
| K 000                                                          | INITIAL COMMENTS<br><br>42 CFR 483.70(a)<br><br>The facility must meet the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | K 000                                                                      |                                                                                                                          |  |                                                        |
| K 921<br>SS=F                                                  | Electrical Equipment - Testing and Maintenance<br>CFR(s): NFPA 101<br><br>Electrical Equipment - Testing and Maintenance Requirements<br>The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. | K 921                                                                      |                                                                                                                          |  | 8/15/23                                                |

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

TITLE

(X6) DATE

Electronically Signed

07/25/2023

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: 07/28/2023  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                            |                                                        |
|----------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255313</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01 - MAIN BUILDING</b><br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/12/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>DUGAN MEMORIAL HOME</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>26894 EAST MAIN STREET<br/>WEST POINT, MS 39773</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                       | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X5)<br>COMPLETION<br>DATE |                                                        |
| K 921                                                          | <p>Continued From page 1</p> <p>10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on the observation, the facility failed to provide electrical equipment in accordance with NFPA 99 Chapter 10. This standard deficiency affected two (2) of three (3) smoke compartments on the facility on the day of Survey.</p> <p>Findings Include:</p> <p>On 7/12/23 at 10:30 AM, observation revealed microwaves plugged and used in the electrical outlets in the following residents' rooms of the facility:</p> <p>Resident Room # 6A</p> <p>Resident Room # 9A</p> <p>Resident Room # 12A</p> <p>Resident Room # 23B</p> <p>Resident Room # 32A</p> <p>The finding was acknowledged by the Administrator and Maintenance Supervisor verified this observation during the exit interview on 7/12/23.</p> | K 921                                                                      | <ul style="list-style-type: none"> <li>• Microwaves were unplugged and removed by maintenance staff from resident rooms #6, #9, #12, #23B, #32A on 07/12/2023.</li> <li>• All residents that had microwaves have the potential to be affected.</li> <li>• All residents and families of those with microwaves were contacted and updated on the removal and prohibition of microwaves by Social Services.</li> </ul> <p>Admission packet updated on 7/12/2023 to include microwaves on the prohibited item list. The interdisciplinary team was educated on the removal of microwaves and the update to the prohibited item list by the Administrator.</p> <ul style="list-style-type: none"> <li>• Quality Assurance Committee will meet monthly beginning 08/15/2022 and will assure no microwaves have entered into an resident's room.</li> </ul> |                            |                                                        |